Queen Victoria Hospital
NHS Foundation Trust

Annual Report, Quality Report and Accounts **2015/16**

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

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Introduction

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1.1 Chair's introduction

I am pleased to present the 2015/16 annual report, quality report and accounts for Queen Victoria Hospital NHS Foundation Trust.

QVH had much to be proud of in 2015/16 including a very positive inspection by the Care Quality Commission (CQC) which concluded that our care is outstanding. We continued to receive excellent feedback from patients and made great strides in implementing our longer term *QVH 2020* strategy for delivering excellence.

A major focus in 2015/16 was the preparation for our CQC inspection in November 2015. As an organisation that holds continuous improvement as one of our core values, we were determined to make the most of the opportunity to take pride in the things we do well, to demonstrate our humanity and to examine where we can continue to improve.

The CQC process enabled us to assure ourselves of the quality of care we provide and to identify where we can improve. We can be proud of our good rating across our services, and the recognition that the care we offer our patients is outstanding. Addressing the feedback in the report will be a focus in the coming year. I would like to thank all the staff, patients, governors and members of the community who took the time to share their views and experiences with the inspectors.

The CQC report quite rightly highlighted the challenge we face, as a small specialist hospital, in ensuring we can offer our most critically ill patients timely access to the full range of medical expertise they might require. We have already been considering this issue over the last year in our burns service. Whilst our burns care remains first-class, we do not have access to all the other specialist expertise and facilities that national guidelines and our own clinicians recognise are essential to ensure the very best outcomes for the most ill patients. We have been developing plans to address this, working in partnership with other trusts. Discussions and engagement with patients and stakeholders will continue as we explore options that would enable us to secure our position as the region's specialist centre for burns care and contribute to the development of the regional trauma centre.

During 2015/16 the trust completed a review of its governance. We have made changes to the structure, terms of reference and frequency of meetings of the board and its sub-committees. As a result, we are confident that the attention and time of the board is balanced appropriately to discharge its duties and assure the effectiveness of the trust, with a clear focus on the quality of patient care.

Looking back on my first year as chair, I have learned a great deal and am very grateful to all the staff, governors, patients and members of the community who have made me feel so welcome. The year also saw us complete our board team with the substantive appointments of our new director of nursing, director of finance and a non-executive director. I am pleased with the calibre of our team and confident that we have the expertise and ability to deliver the trust's vision for continued high quality, sustainable, patient-centred care.

Beryl Hobson
Chair

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Performance report

"QVH continued to deliver a strong operational and financial performance in 2015/16 and, most importantly, continued to provide the high quality care of which our staff are rightly proud."

2.1 An overview of performance

Statement from the chief executive

QVH continued to deliver a strong operational and financial performance in 2015/16. In the midst of a very challenging external environment, we performed strongly against both our key quality and financial targets and, most importantly, continued to provide the high quality care of which our staff are rightly proud.

2015/16 was a transitional year as we finalised our new operational structures and completed appointments to the executive team. These appointments were accompanied by further enhancements to our clinical leadership and middle management structures and I am confident that we now have the right leadership team to meet future challenges.

The year also saw us take significant steps forward in delivering our *QVH 2020* strategy. We were the successful bidder for community diagnostic services in East Sussex, and extended our services into community urology and ear, nose and throat services.

Our core surgical services continued to perform strongly with a steady increase in referrals for both the specialist and routine procedures that we offer.

We have made significant steps in developing strategic partnerships with Brighton and Sussex University Hospitals (BSUH) and Horder Healthcare and undertook a successful care vanguard bid in partnership with local GPs in East Grinstead.

Finally, we continued to achieve very high scores in patient satisfaction surveys and the NHS friends and family test and saw significant improvements in our staff survey results, especially for staff engagement which is very important to us.

Statement of the purpose and activities of the foundation trust

Queen Victoria Hospital (QVH) is a regional and national centre for maxillofacial, reconstructive plastic and corneoplastic surgery, as well as for the treatment of burns. It is a surgical centre for skin cancer and for head and neck cancer and provides microvascular reconstruction services for breast cancer patients following, or in association with, mastectomy.

QVH has links with the operational delivery network for cancer and trauma care covering Kent, Surrey, and Sussex. In addition, QVH is involved in a number of multi-disciplinary teams throughout the region.

In 2015/16, the principal activities of the trust were the provision of:

- plastic surgery (including reconstructive surgery for cancer patients) and burns care;
- head, neck, and dental services (including associated cancer surgery and orthodontics);
- sleep disorders services;
- a wide range of therapy services and community-based services; and
- a minor injuries unit.

QVH operates from its 'hub' hospital site in East Grinstead, West Sussex. Reconstructive surgery services are also provided by QVH in 'spoke' facilities at other hospital sites across Kent, Surrey and Sussex. In particular, QVH provides services on behalf of the following neighbouring trusts:

- Surrey and Sussex Healthcare NHS Trust;
- Brighton and Sussex University Hospitals NHS Trust;
- Medway NHS Foundation Trust;
- East Sussex Healthcare NHS Trust;
- East Kent Hospitals University NHS Foundation Trust; and
- Maidstone and Tunbridge Wells NHS Trust.

A brief history of the foundation trust and its statutory background

QVH is a specialist NHS hospital providing life-changing reconstructive surgery, burns care and rehabilitation services for people across the south of England.

Our world-leading clinical teams also treat common conditions of the hands, eyes, skin and teeth for the people of East Grinstead and the surrounding area. In addition, we provide a minor injuries unit, expert therapies and a sleep disorders service.

We are a centre of excellence, with an international reputation for pioneering advanced techniques and treatments. Everything we do is informed by our passion for providing the highest quality care, the best clinical outcomes and a safe and positive patient experience.

QVH was authorised as one of the country's first NHS foundation trusts in July 2004. We have around 7,600 public members in Kent, Surrey and Sussex.

Keys issues and risks that could affect the foundation trust in delivering its objectives

The trust has an established strategy known as *QVH 2020: Delivering Excellence*. It has developed its strategic emphasis across five domains of excellence which comprise the following key strategic objectives (KSOs):

1. Outstanding patient experience

   We put patients at the heart of safe, compassionate, competent care provided by well-led teams in an environment that meets the needs of patients and their families.

2. World class clinical services

   We provide a portfolio of world class services that are evidenced by clinical and patient outcomes and underpinned by our reputation for high quality education and training and innovative research and development.

3. Operational excellence

   We provide streamlined services that ensure our patients are offered choice and are treated in a timely manner.

4. Financial sustainability

   We maximise existing resources to offer cost-effective and efficient care whilst looking for opportunities to grow and develop our services.

5. Organisational excellence

   We seek to maintain and develop a strong professional and caring culture through clear standards, high expectations and exemplary leadership.

In 2015/16 the QVH board of directors developed significantly its board assurance framework (BAF) to better track the principle risks to the achievement of the KSOs. In conjunction with the BAF, the board also reviewed regularly the corporate risk register (CRR) to track risks to the trust's operational activities. Both tools set out the measures in place to mitigate and manage risks and track progress and both were updated regularly and monitored by the board at its routine meetings. Papers for meetings of the board of directors held in public are published on the QVH website and are available in full from: www.qvh.nhs.uk/about-us/board-of-directors/meetings-in-public

The principle risks identified in the BAF are as follows:

1. Outstanding patient experience

   The QVH estate is aging and has significant backlog maintenance requirements that could compromise patient privacy and patient experience overall.

2. World class clinical services

   The absence of co-located general medical services puts pressure on the ability of the trust to provide a safe and effective out-of-hours service.

3. Operational excellence

   Recent changes to access targets and the complexity of the cancer pathway challenge the trust's ability to meet national targets.

4. Financial sustainability

   The wider challenges to NHS finances and the uncertain policy environment put pressure on the trust's ability to maintain financial balance.

5. Organisational excellence

   Increasing vacancy levels, especially among nursing staff, challenge the trust's ability to maintain quality standards.

Going concern

After making enquiries, the directors have a reasonable expectation that Queen Victoria Hospital NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts that follow in this report.

2.2 Performance analysis

How we measure performance

The trust measures performance against a range of key indicators that include access targets, quality standards and financial requirements. Priority indicators are those included within the Monitor *Risk Assessment Framework* and the quality schedules of our signed contracts with commissioners.

Oversight and scrutiny of performance is achieved by the adoption and implementation of a performance framework against which the relevant directorates and managers are held to account. There are internal triggers in place so that all variances against plan are identified as early as possible to ensure that mitigating actions are put in place. These are monitored at monthly performance

review meetings by a panel of executive team members chaired by the director of finance and including the directors of nursing, operations and human resources and organisational development. The panel meets with the relevant clinical directors, business unit managers and HR and finance business partners to review each directorate's performance.

Assurance is provided to the board via the finance and performance and quality and governance committees as follows:

- To assure the board of directors of in-year delivery of financial and performance targets, the finance and performance committee maintains a detailed overview of the trust's assets and resources in relation to the achievement of its financial plans, the trust's workforce profile in relation to the achievement of key performance indicators and the trust's operational performance in relation to the achievement of its activity plans.
- On behalf of the board of directors, the quality and governance committee is responsible for the oversight and scrutiny of the trust's performance against the three domains of quality (safety, effectiveness and patient experience), compliance with essential professional standards, established good practice and mandatory guidance and delivery of national, regional, local and specialist care quality (CQUIN) targets.

Analysis and explanation of development and performance

Governance

In 2015/16 the board of directors completed a detailed review of its corporate governance arrangements. The board implemented a range of recommendations to ensure that:

- an effective governance structure is in place to enable and support QVH to meet its strategic objectives and ensure compliance with regulatory requirements; and
- governance structures are fit for purpose and in line with best practice in the NHS (including the *Monitor Well-led framework for governance reviews*) and other sectors.

The review paid particular attention to assurance mechanisms and the board agreed a series of changes to strengthen board assurance including:

- the board of directors will alternate its monthly meetings between a formal business agenda and an informal seminar session to allow more protected time for strategy development, interaction with staff and patients and board development;
- the establishment of a new board sub-committee (the finance and performance committee) which will meet monthly to assure the board of the in-year delivery of financial and performance targets and strategic initiatives; and
- the quality and governance (previously quality and risk) committee will meet monthly instead of bi-monthly. This will enable more regular assurance of quality and risk matters in parallel with the work of the finance and performance committee.

As a result of the governance review, the trust's suite of governing documents, including standing orders, standing financial instructions and terms of reference for board sub-committees, has been thoroughly reviewed, amended and implemented.

Care quality

The Care Quality Commission (CQC) conducted a full inspection of the trust on 11 and 12 November 2015 and an unannounced inspection on 23 November 2015. Its judgement of the quality of care offered by QVH was based on a combination of the inspection findings, information from the CQC intelligent monitoring system, information submitted by QVH and information given by the public and other stakeholder organisations.

The overall rating for the trust was 'good' including a rating of 'outstanding' for care.

An action plan has been compiled from the recommendations and this is monitored by the quality and governance committee on behalf of the board of directors.

No concerns about QVH care quality were raised in 2015/16 by the regulators Monitor or the CQC. Monitor rates QVH as 'green' for quality.

Infection control

QVH had one case of Clostridium difficile in 2015/16 against a target of zero. This did not affect the governance risk rating as it was below the de minimis level of 12 cases. QVH had no cases of MRSA bacteraemia in the year.

Waiting times

The recording and reporting of referral to treatment (RTT) waiting times for consultant-led elective care was amended nationally with effect from 1 October 2015. Following a review by Sir Bruce Keogh, it was agreed that the incomplete pathway standard should be the sole measure of a patient's right to start treatment within 18 weeks. To this end, for quarters 3 and 4 of 2015/16, QVH was monitored against the target of at least 92% of patients on active waiting lists waiting less than 18 weeks.

For quarters 1 and 2 of 2015/16, the trust was monitored against three RTT targets for the admitted, non-admitted and open pathways.

QVH achieved its RTT targets for quarters 1 and 2 and the revised target for quarters 3 and 4. However, the original and revised targets continue to prove challenging. The small and specialist nature of QVH sub-specialties results in a small denominator meaning that relatively small shifts in either demand or capacity can have a significant impact on RTT performance. Similarly, the recent change preventing the inclusion of patient pauses has proved challenging for the same reason.

However, QVH continues to ensure that all patients are prioritised according to clinical urgency and chronological order. To this end we continually review and revise our monitoring and tracking systems, most notably our patient treatment lists (PTLs) to ensure that these priorities are being met. In addition, we regularly review our demand and capacity modelling to ensure that we have both the immediate and longer-term capacity to sustain our access standards.

In respect of cancer access standards, we continue to meet all targets with the exception of the 62-day GP to first treatment target (which is different from the 62-day consultant upgrade to first treatment). In this respect, the main challenge is the receipt of patients very late in the referral pathway. Considerable work has been undertaken with referring organisations to minimise delays.

In addition, as with RTT targets, we continue to review and revise our cancer PTLs to ensure our tracking and performance monitoring is fit for purpose, review our demand and capacity modelling and improve training and wider awareness across the trust to ensure that our patients continue to receive prompt and effective care across all pathways.

Financial plan

QVH planned to deliver an operational surplus of £1m in 2015/16. Significant cost pressures emerged during the year, principally related to historic investment decisions, a shift in elective case-mix, a fall in non-elective activity and industrial action by junior doctors. The trust formulated and delivered plans to address the financial gap and delivered an operational surplus of c£0.8m.

The main headlines of financial performance for 2015/16 are:

- Operational surplus of £767k
- The overall income and expenditure position, as detailed in the statement of comprehensive income set out in the accounts at section 6 is a surplus of £5.1m including the effect of revaluation adjustments
- The financial sustainability risk rating (FSRR), calculated as per the guidance in the Monitor *Risk Assessment Framework,* is '4'.

Trusts submit a financial plan to Monitor at the beginning of each financial year to set out detailed plans in line with regulator expectations. QVH performance against its plan for FSRR is shown in section 3.5 'regulatory ratings'.

Statement of comprehensive income

The table below is an extract of the table in the accounts at section 6 that shows the total value for income and expenditure for the financial year.

STATEMENT OF COMPREHENSIVE INCOME FOR THE PERIOD ENDED 31 MARCH 2016	
	2015/16 £000
Operating income	**65,723**
Operating expenses	**(63,104)**
Operating surplus/(deficit)	**2,619**
Net finance costs	**(1,173)**
SURPLUS/(DEFICIT) FOR THE YEAR	**1,446**
Other comprehensive income:	
Revaluation gains/(losses) on property, plant and equipment	3,916
Impairment through revaluation reserve	(229)
INCOME/(EXPENSES) FOR THE PERIOD	**5,133**

An independent professional valuer completed a 'desktop plus' valuation of land, buildings and fixtures in year. There was a £4.3m increase in the assets' values arising from the revaluation and £3.7m was recognised in the revaluation reserve and £679k within the income and expenditure account to reflect reversing impairments recognised in previous periods.

Income

The trust received £59m, the majority of its income, from the provision of healthcare services.

In addition, the trust received income of £1.4m from Health Education England to support the cost of providing training and education to medical and other NHS staff.

Operating expenses

The trust incurred £63m of operating expenses in 2015/16. This includes costs of £41.4m (66% of total operating expenditure) to employ, on average over the year, 914 members of staff.

Non-pay expenditure included £21.7m of operating expenditure and finance costs of £1.2m. Operating expenditure includes drug costs of £1.4m, supplies and services costs of £9m, premises costs of £2.5m and depreciation and amortisation of £2.6m.

Capital

Capital expenditure equated to £4.4m in 2015/16. The table below details the investments made.

CAPITAL PROGRAMME 2015/16	
	£000
Building and infrastructure	557
Medical equipment	646
Information, management and technology	3,224
Total	**4,427**

Cash

The trust has a cash balance of £7.3m, which represents 42 days of operating expenditure. The interest received by the trust during 2015/16 was low, reflecting current economic conditions. The majority of funds are invested with the Government Banking Service (GBS).

Environmental matters

An assessment of energy saving opportunities for QVH was undertaken by the Carbon Trust in May 2010. Its report states that QVH has a heated volume of 19,000m^3. The degree-day corrected delivery energy consumption per annum was 27,556GJ consisting of

- Electricity 36%
- Gas 64%.

This results in the emission of 655,514KG of carbon annually.

Ongoing works to reduce these emissions include:

- Installation of a building management system to monitor major equipment across much of the site
- Variable speed drives fitted to some larger fan motors
- Passive infrared controls for operating theatre heating ventilation and air conditioning plant
- Lighting upgrades during refurbishments
- Installation of double glazing in various locations
- Addition of roof insulation during refurbishments.

It is estimated that the effect of implementing these changes will be a reduction in primary energy consumption of 10.5%.

Validation of achievement is to be assessed during quarters 1 and 2 of 2016/17 and new five-year targets will be proposed.

Social, community and human rights issues

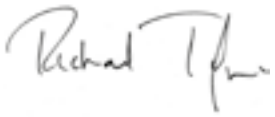
QVH seeks to play a significant role in the local community of East Grinstead and the wider regional community of its patient population. Within East Grinstead, QVH is working closely with local GPs to develop enhanced services for the local population. During 2015/16 QVH was part of a successful joint bid with East Grinstead GPs to be part of the primary care vanguard project which aims to enhance services for targeted vulnerable groups within the community. More widely, QVH has undertaken community engagement in proposed changes to the trust's burns services and was praised by the local Healthwatch for its commitment to public and stakeholder engagement during this process.

Important events since the end of the financial year

On 26 April 2016 the Care Quality Commission published the findings of its comprehensive routine inspection carried out in November 2015. QVH was rated overall as 'good' by the inspectors with patient care rated as 'outstanding'. QVH was pleased to receive this seal of approval as a safe and well-led hospital offering outstanding care and believes it provides a strong foundation as the trust continues to strive to deliver excellence for its patients. The feedback from the inspection and formal recommendations from the report have been added to the ongoing trust-wide continuous improvement action plan, with staff from all teams involved in developing and implementing their own local action plans.

Overseas operations

QVH has no overseas operations.



Richard Tyler
Chief Executive and Accounting Officer
23 May 2016

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Accountability report

"The CQC undertook a full inspection of the trust in November 2015. The overall rating for the trust was 'good' and care quality was rated as 'outstanding'."

3.1 An overview of performance

Disclosures

Directors' disclosures

In 2015/16 the following individuals served as directors of the trust:

NAME	POSITION
Ginny Colwell	Non-Executive Director
Steve Fenlon	Medical Director
Beryl Hobson	Chair
Ian Playford	Non-Executive Director (from 10 April 2015)
Lester Porter	Senior Independent Director and Non-Executive Director
Clare Stafford	Director of Finance (from 1 June 2015)
Jo Thomas	Interim Director of Nursing (from 2 February 2015 to 29 May 2015) and Director of Nursing (from 1 June 2015)
John Thornton	Non-Executive Director
Dominic Tkaczyk	Interim Director of Finance (from 1 December 2014 to 9 June 2015)
Richard Tyler	Chief Executive

Biographies for all current directors of the trust are provided at appendix 7.3.

Details of company directorships and other significant interests held by directors or governors which may conflict with their management responsibilities can be accessed from the papers of meetings of the board of directors held in public which are available in full from the QVH website at www.qvh.nhs.uk/about-us/board-of-directors/meetings-in-public.

The directors of QVH are responsible for preparing this annual report and the quality report and accounts and consider them, taken as a whole, to be fair, balanced and understandable and to provide the information necessary for patients, regulators and other stakeholders to assess the trust's performance, business model and strategy.

For each individual who is a director at the time this annual report was approved:

- as far as the directors are aware, there is no relevant audit information of which the NHS foundation trust's auditor is unaware; and
- the directors have taken all the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the NHS foundation trust's auditor is aware of that information.

Other disclosures

In 2015/16 the trust neither made nor received any political donations.

The better payment practice code requires QVH to pay all valid invoices within the contracted payment terms or within 30 days of receipt of goods or a valid invoice, whichever is later. The table on page 17 demonstrates the performance achieved in 2015/16 compared to 2014/15.

In 2015/16 the trust did not incur any expenditure relating to the late payment of commercial debt under the Late Payment of Commercial Debts (Interest) Act 1998.

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. In 2015/16 QVH has met this requirement.

Section 43(3A) of the NHS Act 2006 requires an NHS foundation trust to provide information on the impact that other income it has received has had on its provision of goods and services for the purposes of the health service in England. QVH does not receive any other income that materially impacts (subsidises) its provision of goods and services for the purposes of the health service.

Enhanced quality governance reporting

The trust's quality governance systems and process have been reviewed during 2015/16 as part of the wider review of board-level governance (see section 2.2 and row 13 of section 3.4). From an enhanced quality perspective this included revising terms of reference for the quality and governance sub-committee (QGC) of the board of directors and compiling a quality assurance framework.

QVH has a robust quality governance framework which provides the board of directors, council of governors, senior managers, clinicians, commissioners and regulators with assurance that essential standards of quality and safety are delivered. The framework also provides assurance that the process for quality governance reporting is embedded throughout the whole organisation.

BETTER PAYMENT PRACTICE CODE PERFORMANCE				
	Year ended 31 March 2016		Year ended 31 March 2015	
	Number	£000	Number	£000
Total bills paid in year	18,262	27,096	16,875	21,902
Total bills paid within target	15,401	22,359	11,311	14,349
Percentage of bills paid within the target	**84%**	**83%**	**67%**	**66%**

The framework consists of agreed pathways for feedback and escalation from all quality groups within the organisation to the QGC. The QGC has an annual work plan but its terms of reference allow it to act responsively when considered necessary and to commission additional quality 'deep dives' to thoroughly investigate issues of concern.

The QVH strategy for quality, published in 2015/16, is integral to the trust's strategy of delivering excellence whilst sustaining financial stability. At every board meeting there is a detailed quality report and a report from the chair of the QGC to provide assurance about the quality of care and services provided by the trust. The board assurance framework and the corporate risk register are also reviewed by the board at each of its meetings held in public. This process enables a detailed discussion about quality and informs decisions about how to address gaps or monitor controls to sustain and improve performance against essential standards of quality and safety. Named directors are responsible for key strategic objectives which each incorporate quality indicators. In addition, the director of nursing leads on quality for the organisation.

Quality is a standing item considered at staff briefing meetings, trust leadership forum meetings, clinical cabinet meetings and meetings of the joint hospital governance group. Together these sessions contribute to a quality-focused culture and empower managers and clinicians to lead on local quality matters. Each team or department has its own monthly governance meeting chaired by a clinical lead and supported by the risk management team and data from the informatics team. Quality and safety are integrated into these agendas and the teams have individual risk registers. Any risk scoring 12 or above is escalated to the corporate risk register to raise awareness in the organisation and to provide additional scrutiny that the right actions are in place.

All serious incidents are reported to the board of directors and, following the root-cause analysis process conducted for any serious incident, delivery of the subsequent incident action plan is monitored by the QGC.

The CQC undertook a full inspection of the trust on 11 and 12 November 2015 and an unannounced inspection on 23 November 2015. Its judgement of the quality of QVH care was based on a combination of the inspection findings, information from the CQC intelligent monitoring system, information submitted by QVH and information given by the public and other stakeholder organisations. The overall rating for the trust was 'good' and care quality was rated as 'outstanding'. An action plan has been compiled from the recommendations and delivery is monitored by the QGC.

The trust has revised its routine 'compliance in practice' internal inspections to mirror the five domains against which the CQC inspects hospitals. A wide range of staff, governors and stakeholders participate to provide a range of perspectives and constructive challenge. The results of compliance in practice inspections are presented to the QGC.

In 2015/16 there were no material inconsistencies between

- the annual governance statement;
- annual and quarterly board statements required by the *Risk Assessment Framework*, the corporate governance statement submitted with the annual plan, the quality report and the annual report; and
- reports arising from the CQC.

A detailed account of quality can be found in the quality report at section 4 and in the annual governance statement at section 3.7.

3.2 Remuneration report

Annual statement on remuneration

In 2015/16 the nomination and remuneration committee approved a 1% increase to the salaries of the chief executive, director of human resources and organisational development and head of corporate affairs and company secretary. This was the only change to the remuneration of the trust's senior managers and was the first in three years. The committee also agreed a new pay strategy for very senior managers.

Beryl Hobson
Trust Chair and Chair of the Nomination and Remuneration Committee
23 May 2016

Senior managers' remuneration policy

Future policy table (senior managers)

See 'information subject to audit' below.

Notes

The QVH approach to remuneration continues to be influenced by national policy and local market factors. The majority of staff receive pay awards determined by the Department of Health in accordance with their national terms and conditions, such as Agenda for Change, and the pay review bodies for doctors and dentists. In line with Agenda for Change, pay progression is linked with performance and is managed through the appraisal system. Managers are required to authorise pay increments subject to the satisfactory delivery of individual objectives. Although under regular review, QVH does not intend to implement separate arrangements for performance related pay or bonuses in the coming financial year.

Senior managers' pay arrangements are subject to approval by the nomination and remuneration sub-committee of the board of directors. In 2015/16, the committee reviewed the national position with regard to pay for health service managers and agreed to increase the salaries of the chief executive, director of human resources and organisational development and the head of corporate affairs and company secretary by 1%. This was the first increase for three years and was in line with awards paid to staff on national terms and conditions of service. In the year ahead, the committee will receive recommendations from the director of human resources and organisational development based on evidence of health sector pay using e-Reward.co.uk reports which cover pay for senior managers in NHS trusts and foundation trusts.

The effectiveness and performance of senior managers is determined through performance appraisal, linked to the *QVH 2020* long-term strategy. This provides five key strategic objectives from which a set of individual objectives are developed. These are reviewed through the year by the chief executive to determine progress and achievement. The nomination and remuneration committee has not agreed the introduction of performance related pay or bonus payments for senior managers and does not intend to do so in 2016/17.

The majority of staff – whether on national terms and conditions or local arrangements – are contracted on a permanent, full time or part time basis. Exceptions to this are in positions where it is felt that an individual needs to be recruited on a fixed-term contract, or as an off-payroll arrangement, to carry out a specific project which is time limited. This approach enhances control of staffing resources and enables flexibility where this is appropriate to the role. National guidance on notice periods for Agenda for Change staff is followed and is determined by salary banding. The maximum in such cases is three months' salary and is in line with current employment legislation.

Senior managers paid more than £142,500[1]

The trust employs two senior managers on salaries more than £142,500. Both appointments were made before the Treasury guidance and reporting arrangements came into effect. The posts are the chief executive, whose salary has been benchmarked against national and local pay comparisons, and the medical director who receives an allowance for board responsibilities beyond clinical duties that takes his remuneration above £142,500.

[1] £142,500 is the threshold used in the Civil Service for approval by the Chief Secretary to the Treasury, as set out in guidance issued by the Cabinet Office. This currently equates to the Prime Minister's ministerial and parliamentary salary. The Cabinet Office approvals process does not apply to NHS foundation trusts but this is considered a suitable benchmark above which NHS foundation trusts should make this disclosure.

Non-executive directors table

See 'information subject to audit' below.

Service contract obligations

None to disclose.

Policy on payment for loss of office

Termination payments are made within the contractual rights of the employee and are therefore subject to income tax and national insurance contributions. This applies to senior managers whose remuneration is set by the nomination and remuneration committee. Where a senior manager receives payment for loss of office, this is determined by their notice period and does not usually exceed three months.

Statement of consideration of employment conditions elsewhere in the foundation trust

The trust, through the nomination and remuneration committee, takes into account the annual pay awards for all staff in determining pay increases for senior managers and directors. Pay at senior levels has not been increased for the last three years during which time increases for staff on Agenda for Change terms and conditions, and other staff subject to national bargaining, have averaged 1% each year. In 2015/16, the nomination and remuneration committee approved an increase of 1% to the pay of three members of the executive team. The committee took account of the pay of other members of the team but decided that no further increases were necessary as a number of the directors of the trust had been appointed recently.

In addition to the pay and conditions of other NHS staff, the nomination and remuneration committee also took into account comparison data taken from the Income Data Services (IDS) NHS boardroom pay report 2014. This highlights the pay for a number of senior level posts from chief executive to company secretary and includes total remuneration. The comparisons considered were basic salary for the post in similar NHS hospitals and variations by geographic location. The trust does not pay bonus payments to any senior managers and therefore the comparison with basic pay at other trusts is appropriate in determining pay increases.

Annual report on remuneration

Information not subject to audit

Service contracts

NAME	POSITION	START DATE	TERM	NOTICE PERIOD
Kathleen Anderson	Head of Corporate Affairs and Company Secretary	1 July 2009	Permanent	3 months
Graeme Armitage	Director of Human Resources and Organisational Development	1 April 2013	Permanent	3 months
Stephen Fenlon	Medical Director	1 April 2013	Permanent	3 months
Sharon Jones	Director of Operations	1 June 2015	Permanent	3 months
Jane Morris	Interim Director of Operations	1 June 2014	Temporary	3 months
Clare Stafford	Director of Finance	1 June 2015	Permanent	3 months
Jo Thomas	Interim Director of Nursing	2 February 2015	Secondment	1 month
Jo Thomas	Director of Nursing	1 June 2015	Permanent	3 months
Dominic Tkaczyk	Interim Director of Finance	1 December 2014	6 months	1 month
Richard Tyler	Chief Executive	1 June 2013	Permanent	6 months

Remuneration committee

The nomination and remuneration committee met five times in 2015/16 to review and make recommendations to the board of directors on the composition, balance, skill mix and succession planning of the board. Additionally, the committee makes recommendations on the appointment of executive directors and is responsible for setting the overall strategy for the remuneration of all staff.

The board of directors has delegated authority to the committee to be responsible for the remuneration packages and contractual terms of the chief executive, executive directors and other senior managers reporting to the chief executive.

Details of the membership of the nomination and remuneration committee and of the number of meetings and individuals' attendance at each is disclosed in appendix 7.1. The committee was materially assisted in its considerations at all meetings held in 2015/16 by Graeme Armitage, Director of Human Resources and Organisational Development.

In 2015/16 the committee determined and pursued its work programme which was particularly focused on the composition of and recruitment to the senior team led by the chief executive following a process of organisational restructuring and a number of unplanned vacancies. In addition, the committee reviewed and approved the new pay strategy for senior managers and addressed the issues raised in the Secretary of State's letter of June 2015 regarding very senior managers' pay. The letter stressed the remuneration of senior appointments which are above that of the prime minister (£142,500 per annum). No appointments to QVH posts exceeded this benchmark in 2015/16.

Disclosures required by the Health and Social Care Act

Directors

Information on the remuneration of the directors and on the expenses of directors is provided in the 'information subject to audit' section below.

Governors

Information on the expenses of the governors is provided in the table below:

1 APRIL 2015 TO 31 MARCH 2016		
Total number of governors in office	**Number of governors receiving expenses in 2015/16**	**Aggregate sum of expenses paid in 2015/16 (rounded to the nearest £00)**
28 served for all or part of 2015/16	2	£300
1 APRIL 2014 TO 31 MARCH 2015		
Total number of governors in office	**Number of governors receiving expenses in 2014/15**	**Aggregate sum of expenses paid in 2014/15 (rounded to the nearest £00)**
31 served for all or part of 2014/15	2	£1,400

Information subject to audit

SALARY AND PENSION ENTITLEMENTS OF SENIOR MANAGERS							
A) Remuneration	**2015/16**						
Name and title	**Salary**	**Benefits in kind**	**Annual performance-related bonus**	**Long-term performance-related bonus**	**Pension-related benefits**	**Other remuneration**	**Total remuneration**
	(bands of £5,000) £000	Rounded to the nearest £100	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000
V Colwell (Non-Executive Director)	10-15	1,300	0	0	0	0	15-20
S Fenlon (Medical Director)	150-155*	0	0	0	30-32.5	0	185-190
B Hobson (Chair)	40-45	2,000	0	0	0	0	45-50
I Playford (Non-Executive Director)	10-15	200	0	0	0	0	10-15
L Porter (Non-Executive Director)	10-15	0	0	0	0	0	10-15
C Stafford (Director of Finance)	100-105	0	0	0	25-27.5	5-10	135-140
J Thomas (Director of Nursing)	100-105	0	0	0	227.5-230	0	330-335
J Thornton (Non-Executive Director)	10-15	0	0	0	0	0	10-15
D Tkaczyk (Interim Director of Finance)	55-60	0	0	0	0	0	55-60
R Tyler (Chief Executive)	145-150	0	0	0	15-17.5	0	160-165
** Salary attributable to the medical director's clinical role is £137,403.12*							

	2014/15						
S Butt (Interim Director of Finance)	120-125	0	0	0	0	0	120-125
V Colwell (Non-Executive Director)	10-15	800	0	0	0	0	15-20
S Fenlon (Medical Director)	150-155*	100	0	0	65-67.5	0	215-220
P Griffiths (Chairman)	40-45	700	0	0	0	0	45-50
R Hathaway (Director of Finance)	10-15	100	0	0	5-7.5	0	15-20
B Hobson (Chair)	15-20	600	0	0	0	0	15-20
A Parker (Director of Nursing and Quality)	75-80	200	0	0	0	0	95-100
L Porter (Non-Executive Director)	10-15	0	0	0	0	0	10-15
J Thomas (Interim Director of Nursing)	15-20	0	0	0	0	0	15-20
J Thornton (Non-Executive Director)	10-15	300	0	0	0	0	15-20
D Tkaczyk (Interim Director of Finance)	115-120	0	0	0	0	0	115-120
R Tyler (Chief Executive)	140-145	0	0	0	162.5-165	0	305-310
** Salary attributable to the medical director's clinical role is £139,003.12*							

No performance related bonus was paid in 2015/16 or 2014/15.
Other remuneration represents non-taxable relocation payments.
R Hathaway left the trust on 8 December 2014.
S Butt left the trust on 12 December 2015.
D Tkaczyk joined the trust on 15 December 2014 and left on 4 June 2015.
J Thomas joined the trust on 2 February 2015.
P Griffiths left the trust on 31 March 2015.
B Hobson joined the trust on 1 July 2014.
C Stafford joined the trust on 1 June 2015.
I Playford joined the trust on 10 April 2015.

SALARY AND PENSION ENTITLEMENTS OF SENIOR MANAGERS						
B) Pension benefits						
Name and title	**Real increase in pension at age 60**	**Lump sum at age 60 related to real increase in pension**	**Total accrued pension at age 60 at 31 March 2016**	**Lump sum at age 60 related to accrued pension at 31 March 2016**	**Cash equivalent transfer value at 31 March 2016**	**Cash equivalent transfer value at 31 March 2015**
	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	£000	£000
S Fenlon (Medical Director)	0-2.5	0-2.5	50-55	140-145	847	837
C Stafford (Director of Finance)	0-2.5	0-2.5	25-30	80-85	406	404
J Thomas (Director of Nursing)	10-12.5	25-27.5	30-35	85-90	527	358
R Tyler (Chief Executive)	0-2.5	2.5-5	35-40	110-115	690	652

As non-executive directors do not receive pensionable remuneration, there are no entries in respect of pensions for non-executive directors.

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies.

The CETV figures include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

The real increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

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

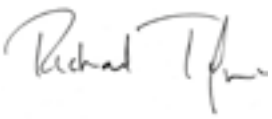
Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

The median remuneration of all the trust's staff is £27,936.

The ratio of the mid-point of the banded remuneration of the highest paid director to the median is 5.5 to 1.

There were no payments to senior managers for loss of office during the year.

There were no payments to past senior managers during the financial year.



Richard Tyler
Chief Executive and Accounting Officer
23 May 2016

3.3 Staff report

Analysis of average staff numbers

The table below outlines the average number of staff employed by the trust throughout 2015/16.

PERMANENTLY EMPLOYED													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average
Headcount	973	971	980	979	983	987	991	998	993	992	990	1,008	**987**
FTE	824.38	822.75	831.87	832.62	836.29	838.86	843.61	847.97	845.55	843.74	840.71	856.83	**838.77**
TEMPORARY STAFF-BANK, LOCUM, AGENCY													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average
Non-medical bank	29.99	26.14	28.68	30.35	28.33	29.18	28.75	31.13	29.08	30.90	33.21	38.07	**30.32**
Non-medical agency	28.32	28.32	28.32	38.24	25.64	14.84	25.98	28.96	42.84	20.33	26.23	33.17	**28.43**
Medical locums	1.20	1.20	1.00	1.00	2.00	2.00	2.00	2.00	2.00	3.00	3.00	3.00	**1.95**
Medical bank	2.07	2.37	3.86	2.82	1.15	2.53	1.59	2.03	2.02	0.95	1.88	1.63	**2.08**
Medical agency	2.00	2.00	1.00	1.00	1.00	2.00	1.00	1.00	1.00	1.00	1.00	1.00	**1.25**
Total average full time equivalent staff numbers 2015/16													**902.79**

Breakdown at the year end of the number of male and female directors, other senior managers and employees

	Chief executive	Executive directors	Non-executive directors	Other senior managers	All other employees	Total
Female	0	3	2	5	778	788
Male	1	2	3	3	211	220
Total						**1008**

Sickness absence data

Total full time equivalent staff years available	Total days lost	Average number of days of sickness absence per full time equivalent employee
840	9,922	7.3

Figures provided by the Health and Social Care Information Centre based on the 2015 calendar year. The Department of Health considers these figures to be a reasonable proxy for financial year equivalents.

Staff policies and actions applied during the financial year

During 2015/16, QVH undertook a wide review and update of all staff policies. This provided up-to-date employment policies that are in line with current good practice and ensures that applicants and employees are treated fairly and equitably. Key staff policies include:

- Dignity and respect at work
- Whistleblowing
- Employee break scheme
- Flexible working
- Managing sickness absence
- Paternity, maternity and adoption leave
- Recruitment and selection
- Redeployment.

Policies applied during the financial year for giving full and fair consideration to applications for employment made by disabled persons, having regards to their particular aptitudes and abilities	QVH has a positive approach to applications from people with disabilities and makes adjustments where appropriate for interview and employment. The revised recruitment and selection policy ensures that recruiting managers are aware of the requirements under the Equalities Act 2010 regarding making reasonable adjustments, including adaptations to the working area to allow greater access. This applies equally to those applying to work for the trust and those already employed by the trust.
Policies applied during the financial year for continuing the employment of, and arranging appropriate training for, employees who have become disabled persons during the period	The managing sickness absence policy has been updated to provide managers with guidance on managing short and long term sickness. This is supplemented with training sessions and ongoing support for managers from the human resources team. Managers are provided with advice on potential adaptations, such as buying specialist equipment, that may be necessary to enable staff to continue in work if they develop a disability. For example, QVH has invested in voice recognition equipment to enable a member of staff to continue working.
Policies applied during the financial year for training, career development and promotion of disabled employees	Delivery of training is under regular review as part of the trust's equality strategy action plan and implementation of the Equality Delivery System 2. QVH works with disabled staff as individuals, discussing their needs on a case-by-case basis. QVH continues to apply the principles of the 'two ticks' disability employer scheme.
Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees	The executive team hosts monthly all staff briefing sessions. Chaired by the chief executive, the sessions include briefings on the trust's latest quality, operational, financial and workforce performance metrics and analysis. The sessions also include presentations on key developments and opportunities for staff to ask any questions. Notes of the sessions are taken and published on the staff intranet. All staff receive a fortnightly newsletter by email (or print for staff without regular email access) which includes a front-page briefing along with other news and alerts. The newsletter and previous issues are always available on the staff intranet site. Important news and developments are reported to staff in real time by email whenever necessary. In 2015/16 QVH concluded a project to launch a new intranet site for staff that uses modern, supported software. The new facility represented a significant investment in internal communications and has been very well received and further developed by staff.

Actions taken in the financial year to consult with employees and their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests	QVH has good working relationships with its staff-side representatives and meets with them regularly to discuss the performance of the trust in terms of its financial position and continuous improvement of care quality. Formal consultation with staff is driven through the: • Joint consultation and negotiating committee comprising trade union and management representatives; and • Local negotiating committee involving managers and medical staff representatives and including a British Medical Association representative.
Actions taken in the financial year to encourage the involvement of employees in the NHS foundation trust's performance	In 2015/16 QVH introduced breakfast sessions for any members of staff to talk about their views and concerns with the chair and chief executive. We have also surveyed all staff to explore how we can provide better opportunities to inform them to take part in decision making within the trust and to help us shape our future direction. The results from the survey are in the process of being implemented. Whilst QVH has an open and supportive culture, it is important that we also provide other opportunities for staff to raise concerns safely without fear. As such we have revised our whistleblowing policy in line with Sir Robert Francis QC's report on the *Freedom to Speak Up* review and recommendations of the independent report for the Secretary of State for Health *Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile*. The policy now better enables staff to raise concerns anonymously, which can then be formally investigated.
Information on health and safety performance and occupational health	QVH has a health and safety committee which regularly receives reports from across the trust highlighting any risks and how they are being addressed. In addition, the human resources department provides quarterly Information on the support provided to staff through Team Prevent, our occupational health provider, to the quality and governance committee. This includes access to flu vaccinations, counselling services, needle stick injury advice and support in return to work following long term sickness absence. In-year changes to this service include improved access and the introduction of seven-day-a-week telephone advice. This year we improved our occupational health service and introduced an employee health and wellbeing service. This provides all staff with a range of support including: • confidential counselling; • stress management; • advice to staff on injuries at work; and • a 24-hour employee assistance programme which provides comprehensive, round the clock phone advice for all staff.
Information on policies and procedures with respect to countering fraud and corruption	QVH takes fraud and corruption very seriously and takes steps to regularly review processes to ensure that opportunities for fraud to take place are minimised. This includes training sessions for staff and managers from the counter fraud team. We also act upon information provided by staff and encourage them to be open at all times where they feel their colleagues are not acting in the best interests of patients or the trust.

Employee policy development in the trust requires there to be an equality impact assessment for each policy. This ensures that no person is disadvantaged by the application of a policy and maintains our approach to supporting employees and applicants irrespective of their disability. As part of this we introduced improved guidance for managers on carrying out these assessments through our equality impact assessments policy.

In addition, we have introduced a new equality strategy providing a greater emphasis on equal opportunities for all staff in terms of career progression and training. The board of directors is provided with an annual report on progress against the equality strategy and the trust publishes data relating to its equality profile on its website. Reports from the equality and diversity group and learning and development strategy group are provided to the quality and governance committee quarterly.

QVH is compliant with the national requirement for the implementation of the Equality Delivery System 2 which includes the publication of our workforce race equality standard. This provides the public with information about the diversity of the trust compared to our local population.

Staff survey results

a) Commentary

Our staff engagement score improved from 3.94 in 2014 to 4.02 in 2015 (compared to a national average of 4.01). This was the result of significant staff engagement sessions carried out as part of the trust's management restructure. The engagement was led by the chief executive and involved numerous open meetings for staff to attend and take part in question and answer sessions. In addition, we have also surveyed views on plans for improving the range of opportunities for staff to become involved in decision-making and setting the strategic direction of the trust.

Survey results have also shown improvements in staff recommending QVH as a place to work or receive treatment, staff motivation at work and their ability to contribute towards improvements at work.

b) Summary of performance – results from the NHS staff survey

There were a number of indicators in 2015 which demonstrated improvement from previous years, including the percentage of staff reporting errors, near misses and incidents, a reduction in the percentage of staff suffering from work related stress and an increase in the number of staff having performance appraisals. These are good indications of the open culture in development across the organisation and the impact of initiatives taken with managers and staff on the effective management of stress at work and mindfulness courses.

The main areas of concern raised in the staff survey were the reporting of bullying and harassment and opportunities for flexible working. The latter score was consistent with the national average and reporting of bullying and harassment is taken very seriously. These concerns are of particular importance to the staff survey action plan now in place. It will deliver further analysis to enable discussion of the results with teams, inform internal questionnaires to better understand the factors that influenced staff responses and refine training sessions for managers and staff.

b) Summary of performance – results from the NHS staff survey (continued)

	2014/15		2015/16		QVH improvement/ deterioration
Response rate	**QVH**	**National average**	**QVH**	**National average**	
	56%	50%	50%	50%	Decrease of 6%

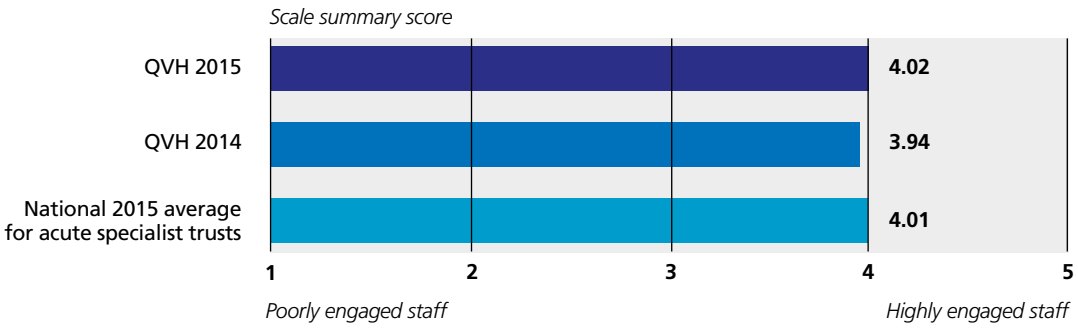
	2014/15		2015/16		QVH improvement/ deterioration
Top four ranking scores	**QVH**	**National average**	**QVH**	**National average**	
KF29: Percentage of staff reporting errors, near misses or incidents	94%	92%	97%	92%	Increase of 3%
KF17: Percentage of staff suffering work related stress	35%	35%	28%	34%	Decrease of 7%
KF1: Staff recommending the organisation as a place to work or receive treatment	4.18	4.14	4.25	4.17	Increase of 0.07 points
KF32: Effective use of patient feedback	New indicator for 2015	Not applicable	3.95	3.80	Not applicable
KF31: Staff confidence/security in reporting unsafe clinical practice	3.75	3.50	3.81	3.75	Increase of 0.06 points

	2014/15		2015/16		QVH improvement/ deterioration
Bottom four ranking scores	**QVH**	**National average**	**QVH**	**National average**	
KF24: Percentage of staff reporting violence	57%	71%	56%	68%	Decrease of 1%
KF27: Percentage of staff reporting recent experience of harassment, bullying or abuse	43%	45%	15%	37%	Decrease of 28%
KF15: Percentage of staff satisfied with opportunities for flexible working	New indicator for 2015	Not applicable	51%	53%	Not applicable
KF16: Percentage of staff working extra hours	69%	Not available*	75%	75%	Increase of 6%
KF13: Quality of non-mandatory training, learning or development	New indicator for 2015	Not applicable	4.01	4.05	Not applicable

*This indicator was reported differently in 2015 so no national average comparison is available.

Overall staff engagement

(the higher the score the better)



The overall indicator of staff engagement has been calculated using the questions that make up key findings (KFs) 1,4 and 7. These KFs relate to the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (KF7); their willingness to recommend the trust as a place to work or receive treatment (KF1); and the extent to which they feel motivated and engaged with their work (KF4).

c) Future priorities and targets

In 2015 QVH continued to see very strong staff survey results with deterioration in only two of the 32 key findings and an improvement in four compared with the 2014 results. The overall response rate was in line with the national average of 50% but will be an area of focus for QVH in 2016. QVH intends to provide more opportunities for staff to complete the survey supported by arrangements for the survey to be completed online. In addition, a central, secure posting location will be provided on-site for staff to return completed paper surveys.

Other priorities include ensuring that the management culture of the organisation remains open and appropriate to the needs of the organisation and its staff. Feedback on the reporting of bullying and harassment will be addressed through active engagement with staff to gain their views and to ensure that training supports all staff.

Performance against priorities will be monitored in the form of the staff survey action plan. Updates will be provided monthly to the human resources and organisational development group. This group consists of executives and operational representatives from across the trust and its role is to review the effective use and development of human resources. In addition, quarterly updates on progress will be provided to the board of directors.

In summary, the QVH priorities for 2016/17 will be to:

- improve the staff survey response rates to 60%;
- address the reporting of bullying and harassment;
- improve access to flexible working options where appropriate and in line with the needs of our services;
- implement opportunities for more staff to be engaged in decision making; and
- continue to improve the appraisal system to offer more opportunities for staff development.

Expenditure on consultancy

During 2015/16, professional advice was taken from Green & Kassab Ltd on options for developing a new estates strategy for QVH. The advice and subsequent report was used to inform discussions and agree the next steps required. The cost of consultancy services was £31,294.

Off-payroll engagements

Use of off-payroll arrangements is subject to authorisation by the board of directors' nomination and remuneration sub-committee. Off-payroll appointments of senior staff are kept to a minimum and are usually reserved for interim engagements when senior vacancies arise and cannot otherwise be managed. Such arrangements are usually subject to maximum periods of six months and, as such, are made in accordance with the regulations set by HMRC.

All off-payroll engagements as of 31 March 2016, for more than £220 per day and that last for longer than six months	
Number of existing engagements as of 31 March 2016	0
Of which:	
Number that have existed for less than one year at the time of reporting	0
Number that have existed for between one and two years at the time of reporting	0
Number that have existed for between two and three years at the time of reporting	0
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	0
All existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.	Not applicable

All new off-payroll engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016, for more than £220 per day and that last for longer than six months	
Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	0
Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations	0
Number for whom assurance has been requested	0
Of which:	
Number for whom assurance has been received	0
Number for whom assurance has not been received	0
Number that have been terminated as a result of assurance not being received	0

Any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2015 and 31 March 2016	
Number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year	1
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year, including both off-payroll and on-payroll engagements	14
Details of the exceptional circumstance that led to each of these engagements	Following the departure of the director of finance in April 2014, an interim appointment was made while a recruitment process was undertaken. When an appointment could not be made, a second interim appointment was made while another recruitment process was undertaken and until the substantive appointment joined the organisation.
Details of the length of time each of these exceptional engagements lasted	During 2015/16, the second interim appointment noted above lasted from December 2014 to June 2015.

Exit packages

Staff exit packages

Foundation trusts are required to disclose summary information on the use of exit packages agreed in the financial year.

Staff exit packages are payable when the trust terminates the employment of an employee before the normal retirement date or whenever an employee accepts voluntary redundancy in return for these benefits.

In 2015/16 QVH did not make any compulsory redundancies and did not agree any other staff exit packages. There was no resource cost for staff exit packages in 2015/16.

2015/16			
	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
Total number of exit packages by type	0	0	0
Total resource cost	0	0	0

In comparison, in 2014/15 there were three cases in which contractual payments were made in lieu of notice as follows:

2014/15			
	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
< £10,000	0	0	0
£10,000 – £25,000	0	2 (payments in lieu of notice)	2
£25,001 – £50,000	0	1	1
£50,001 – £100,00	0	0	0
£100,001 – £150,000	0	0	0
£150,001 – £200,000	0	0	0
>£200,000	0	0	0
Total number of exit packages by type	0	2	–
Total resource cost	**0**	**£59,000**	–

Non-compulsory departure payments

The trust made no non-compulsory departure payments in 2015/16.

In 2014/15, a substantial management re-structure took place. As a result, a number of individuals chose to leave the organisation. In accordance with their contractual entitlements, agreements were reached for them to leave the trust with their notice paid in lieu.

	2015/16		2014/15	
	Number of agreements	Total value of agreements	Number of agreements	Total value of agreements
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	3	£59,000
Exit payments following employment tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	**0**	**0**	**3**	**£59,000**
Of which: Non-contractual payments requiring HMT approval was made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

3.4 NHS foundation trust code of governance disclosures

Statement

Queen Victoria Hospital 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.

Disclosures

	Part of schedule A	Relating to	Code of Governance reference	Summary of requirement
1.	2: Disclose	Board and council of governors	A.1.1	The schedule of matters reserved for the board of directors 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 each of the boards and which are delegated to the executive management of the board of directors.
The schedule of matters reserved for the board of directors was updated in 2015/16 following a detailed review of the trust's standing orders and standing financial instructions. The suite of documents was implemented from 1 April 2016. The schedule includes a series of statements detailing the roles and responsibilities of the council of governors. In 2016/17 separate standing orders for the council of governors will be developed for adoption. The trust's annual plan for 2013/14 describes how any disagreements between the council of governors and the board of directors will be resolved and still stands. It is supported by the trust's constitution and standing orders to provide the framework for decision making and delegation between the board of directors, council of governors and executive management team.				
2.	2: Disclose	Board, nomination committee, audit committee, remuneration committee	A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.
A register of this information is at appendix 7.1.				
3.	2: Disclose	Council of governors	A.5.3	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.
A register of this information is at appendix 7.2.				
4.	Additional requirement of FT ARM	Council of governors	n/a	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.
A register of this information is at appendices 7.1 and 7.2.				
5.	2: Disclose	Board	B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.
This information is included at appendix 7.1.				
6.	2: Disclose	Board	B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.
Directors' biographies are included at appendix 7.3. The trust considers that the board of directors remains balanced, complete, appropriate and compliant with the provisions of the *NHS Foundation Trust Code of Governance* and its own terms of authorisation.				
7.	Additional requirement of FT ARM	Board	n/a	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated.
Details of the length of appointments of the non-executive directors are included at appendix 7.1. Paragraph 35 of the trust's constitution sets out the criteria and process for termination of a non-executive director contract.				

	Part of schedule A	Relating to	Code of Governance reference	Summary of requirement
8.	2: Disclose	Nomination committee	B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.
See section 3.2.				
9.	Additional requirement of FT ARM	Nomination committee	n/a	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.
Not applicable.				
10.	2: Disclose	Chair, council of governors	B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.
A register of directors' interests is kept by the trust and is available at any time on request from the company secretary. From January 2016 the register was also included in full in the papers for meetings of the board of directors held in public. In September 2015, the chairperson's other significant commitments changed when Beryl Hobson concluded her appointed term as chair of the National Childbirth Trust.				
11.	2: Disclose	Council of governors	B.5.6	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.
The QVH annual plan for 2015/16 was presented at the annual members' meeting held on 8 October 2015, to which all members were invited. Regular information on strategy and development is included in the trust's newsletter for members and the general public and in email bulletins to members. Many governors take part in 'compliance in practice' sessions during which they engage with patients and members and provide feedback on their discussions.				
12.	Additional requirement of FT ARM	Council of governors	n/a	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.
Not applicable.				
13.	2: Disclose	Board	B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.
In quarters 1 and 2 of 2015/16 a working group established by the board of directors completed its review of the trust's board-level governance structure and processes. In October 2015 a series of changes to the structure of board sub-committees and the frequency, membership and timing of all board-level meetings was implemented following approval by the board. The review took account of the Monitor *Well-led framework for governance reviews* and best practice from across the foundation trust sector and beyond. The review was internal but the trust intends to commission an independent review of governance in 2017, as required by the *Well-led framework*. This will follow the board's next annual process of self-assessment of its effectiveness, one year following implementation of the recommendations put forward from the governance review. More information and progress reports from the review can be found in papers of the meetings of the board of directors available from the trust's website at: www.qvh.nhs.uk/about-us/board-of-directors/meetings-in-public The performance of the executive directors is assessed by the chief executive taking into account feedback sought from relevant members of staff and the board. The performance of the non-executive directors is assessed by the chair taking into account feedback sought from the executive directors and governors. The performance of the chair is assessed by the senior independent director in collaboration with the chair of the council of governors' appointments committee taking into account feedback sought from directors and governors, particularly the council's governor representatives to the board and its sub-committees. In 2015/16 the trust chair led a review of the process of performance evaluation for directors and the chair. Together with the director of HR and company secretary, the chair aimed to streamline the process, improve the generic questionnaires used to prompt feedback and make governors' input to the process more efficient and meaningful. On this basis a series of refinements to the process were implemented in the final quarter of 2015/16. The process was still in train at the close of the financial year and will be evaluated once it has completed.				

	Part of schedule A	Relating to	Code of Governance reference	Summary of requirement
14.	2: Disclose	Board	B.6.2	Where there has been external evaluation of the board and/or governance of the trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.
Not applicable.				
15.	2: Disclose	Board	C.1.1	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, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). See also ARM paragraph 7.98.
See 'enhanced quality governance reporting' at section 3.1 and the annual governance statement section entitled 'annual quality report' at section 3.7.				
16.	2: Disclose	Board	C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.
See annual governance statement section entitled 'review of effectiveness' at section 3.7.				
17.	2: Disclose	Audit committee, control environment	C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.
In 2015/16 the trust's internal audit function was provided by Mazars Public Sector Internal Audit Limited; a subsidiary of Mazars LLP. The purpose of internal audit is to provide the trust board, via the audit committee, with an independent and objective opinion on risk management, internal control and governance arrangements. The scope of coverage in 2015/16 included: • financial systems and control; • recruitment, retention and payment of and/or to staff; • non-clinical infrastructure including estates, information technology and information governance; and • board assurance framework, risk management and governance documents.				
18.	2: Disclose	Audit committee, council of governors	C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.
Not applicable in 2015/16.				

	Part of schedule A	Relating to	Code of Governance reference	Summary of requirement
19.	2: Disclose	Audit committee	C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.

The audit committee meets quarterly to maintain an effective system of governance, risk management and internal control (including financial, clinical, operational and compliance controls and risk management systems). The committee is also responsible for maintaining an appropriate relationship with the trust's auditors.

Audit committee meetings are attended by the trust's director of finance and other representatives of the trust's risk management functions, the external and internal auditors and local counter fraud service. At the beginning of every audit committee meeting, there is a closed session between the chair of the audit committee and committee members with the internal and external auditors.

During 2015/16:

- The committee received reports from the trust's internal and external auditors that provided the committee with a review of the trust's internal control and risk management systems. The committee considered the key financial estimates when reviewing the financial statements.
- The committee reviewed its effectiveness and made changes to its terms of reference following the wider board-governance review and developed its work programme.
- The internal auditors were able to report full or substantial assurance for 94% of the areas reviewed, resulting in a head of internal audit opinion of 'significant assurance'.
- The council of governors agreed to extend the contract with KPMG for external audit services by a further 12 months from September 2015. It based its decision on an assessment of the work of the external auditors presented to the council by the chair of the audit committee at the council's meeting held in public on 9 July 2015.
- The external auditors did not provide non-audit services.

The main source of income for the trust is the provision of healthcare services to the public under contracts with NHS commissioners. Given the materiality in value and the judgement used in relation to areas such as accruals for services not yet invoiced and partially completed spells, this has been identified as a risk in 2015/16. The trust participates in the national agreement of balances exercise. The agreement of balances exercise identifies mismatches between receivable and payable balances recognised by the trust and its commissioners and all differences are investigated by the finance team.

In 2015/16, foundation trusts had total property, plant and equipment (PPE) of £25.8 billion. Trusts are responsible for ensuring that the valuation of their PPE is correct and for conducting impairment reviews that confirm the condition of these assets. As a result of the suggested accounting policies provided by Monitor, trusts typically achieve this by performing an annual review for impairment, a periodic desk top valuation (every three years) and a full valuation in not more than five-yearly intervals. The asset valuation and impairment review processes are both estimates and therefore present a higher level of risk to the audit. In order to mitigate that risk, the trust undertook a 'desktop plus' valuation and impairment review during 2015/16.

20.	2: Disclose	Board, remuneration committee	D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.

Not applicable.

	Part of schedule A	Relating to	Code of Governance reference	Summary of requirement
21.	2: Disclose	Board	E.1.5	The board of directors should state in the annual report the steps they have 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, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.

The board of directors uses a variety of methods to understand the views of governors:

- A governor representative attends all meetings of the board of directors in full (including seminars, workshops and meeting sessions held in private) and is an active participant. The governor representative is expected to provide feedback to governor colleagues to contribute to the council's statutory duty to hold non-executive directors to account for the performance of the board of directors.
- Directors attend all meetings of the council of governors held in public. In 2015/16 council meeting agendas were further refined to provide more opportunities for non-executive directors to report to the council and for dialogue between non-executive directors and governors generally.
- The board invites a governor representative to attend meetings of its sub-committees to participate and feedback to governor colleagues. As the sub-committees are chaired by non-executive directors this facility gives more governors the opportunity to observe non-executive directors performing their duties as well as providing governors with wider insight into the operational activities of the trust and corporate governance.

Following a review of board-level governance in 2015/16 the board of directors and council of governors agreed a document formalising principles of engagement between the council's governor representatives and the trust's board-level structures and mechanisms.

QVH's governor representative roles foster closer working relationships between governors and NEDs and provide more opportunities for governors to see NEDs at work on a regular basis. As a result, governors are better able to appraise the performance of the NEDs and hold them to account and NEDs are better informed of the views of governors and members.

In line with legislation introduced under the Health and Social Care Act 2012, prior to each meeting a copy of the board of directors' meeting agenda is forwarded to the council of governors. Governors are invited to forward any comments on the agenda and general feedback from governors and members to their governor representative for representation at board meetings.

All directors attend the annual members' meeting and any other members' meetings including those held to support members interested in standing for election as a governor.

22.	2: Disclose	Board, membership	E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.

The trust's membership strategy was reviewed in February 2015. At its meeting on 9 April 2015 the council of governors agreed to add tasks to the membership action plan which focused on member engagement and the representative nature of the membership, including:

- offering electronic voting to all members for whom an email address is held;
- investing in support to contact existing members for whom the trust did not hold an email address with the aim of increasing e-membership to 50% and improving the quality of data held for each member, particularly data relevant to equality, diversity and human rights matters; and
- for the trust to consider investing in a targeted membership recruitment campaign to replenish the membership base by approximately 2,000 new members.

The last task acknowledged that, despite steadily recruiting members using the methods outlined in the strategy, membership has continued to decline as more members have died or moved out of the constituencies served by the trust. Since peaking at approximately 11,000 in late 2009, approximately 25% of members have been lost in five years. Furthermore, people living locally to the trust's East Grinstead 'hub' are well represented among the membership but very few members in this category are under 50 years of age or from ethnic backgrounds that are not white. In addition, a large proportion of the trust's spoke-site activity is delivered in Kent. But, as many QVH patients receive care without attending the trust's 'hub' site, there are limited opportunities to communicate with spoke patients.

Nonetheless, the trust recognises the challenges and limitations of establishing a representative membership base as it serves a large regional population with a range of specialist services and a smaller local population with a range of community services.

23.	2: Disclose	Membership	E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.

Members who wish to communicate with the directors should contact the company secretary on 01342 414362 or info@qvh.nhs.uk. Members who wish to communicate with governors should contact the deputy company secretary on 01342 414200 or hilary.saunders@qvh.nhs.uk. This information is also available from the trust's website at: www.qvh.nhs.uk/about-us/board-of-directors and www.qvh.nhs.uk/for-members/council-of-governors-2

	Part of schedule A	Relating to	Code of Governance reference	Summary of requirement
24.	Additional requirement of FT ARM	Membership	n/a	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership (see also E.1.6 above), including progress towards any recruitment targets for members.
The trust's members belong to either the public or staff constituency. Paragraphs 8 and 9 of the trust's constitution set out eligibility criteria for membership of each constituency. As at 31 March 2016, the number of members within the public constituency was 7,600 and the staff constituency was 998. The trust's membership strategy was reviewed by the trust and presented to governors and non-executive directors at the trust's annual membership meeting on 8 October 2015. It is available online at www.qvh.nhs.uk/for-members/public-meetings				
25.	Additional requirement of FT ARM (based on FReM requirement)	Board, council of governors	n/a	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report. See also ARM paragraph 7.33 as directors' report requirement.
A register of directors' and governors' interest is kept by the trust and is available on request from the company secretary.				
26.	6: Comply or explain	Board	A.1.4	The board should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust's effectiveness, efficiency and economy as well as the quality of its health care delivery.
Compliant.				
27.	6: Comply or explain	Board	A.1.5	The board should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance.
Compliant.				
28.	6: Comply or explain	Board	A.1.6	The board should report on its approach to clinical governance.
The trust's clinical governance group is responsible for: • Ensuring that QVH meets its statutory duty of quality through clinical governance. • Ensuring the best use of available resources for patients by establishing policies for effective clinical services. • Identifying and instigating policy improvement from clinical audit and outcomes monitoring processes. • Identifying and mitigating risks relating to the development and implementation of clinical policy. The group meets monthly and reports to the quality and governance sub-committee of the board which, in turn, provides assurance to the full board of directors. The group is chaired by the medical director and its members include the director of nursing, medical directors of clinical specialties, matrons and service managers.				
29.	6: Comply or explain	Board	A.1.7	The chief executive as the accounting officer should follow the procedure set out by Monitor for advising the board and the council and for recording and submitting objections to decisions.
Compliant				
30.	6: Comply or explain	Board	A.1.8	The board should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life.
The trust's standards of business conduct and behaviour policy was revised and approved by the nomination and remuneration committee in February 2014 and is scheduled for review in 2016/17. In 2015/16 the policy was subject to an internal audit by Mazars as part of the planned work programme. The audit opinion provided as a result was one of 'substantial assurance'.				

	Part of schedule A	Relating to	Code of Governance reference	Summary of requirement
31.	6: Comply or explain	Board	A.1.9	The board should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility.
See row 30 above.				
32.	6: Comply or explain	Board	A.1.10	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors.
Compliant.				
33.	6: Comply or explain	Chair	A.3.1	The chairperson should, on appointment by the council, meet the independence criteria set out in B.1.1. A chief executive should not go on to be the chairperson of the same NHS foundation trust.
Compliant				
34.	6: Comply or explain	Board	A.4.1	In consultation with the council, the board should appoint one of the independent non-executive directors to be the senior independent director.
Compliant. Lester Porter was appointed as the trust's senior independent director in April 2014 in consultation with the council of governors.				
35.	6: Comply or explain	Board	A.4.2	The chairperson should hold meetings with the non-executive directors without the executives present.
Compliant. The chair has held monthly meetings with the non-executive directors throughout the course of 2015/16.				
36.	6: Comply or explain	Board	A.4.3	Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes.
Not applicable in 2015/16.				
37.	6: Comply or explain	Council of governors	A.5.1	The council of governors should meet sufficiently regularly to discharge its duties.
Compliant. The trust's constitution stipulates that the council of governors should meet at least four times per year. During 2015/16 the council of governors held meetings in public on 9 April 2015, 9 July 2015, 8 October 2015 and 14 January 2016.				
38.	6: Comply or explain	Council of governors	A.5.2	The council of governors should not be so large as to be unwieldy.
The council of governors comprises 20 public members, three staff members and three stakeholder representatives, as established by paragraph 14 of the trust's constitution.				
39.	6: Comply or explain	Council of governors	A.5.4	The roles and responsibilities of the council of governors should be set out in a written document.
Monitor publishes guides to the duties and legal obligations of foundation trust governors for governors. General duties of the trust's council of governors are included in provision 19 of the trust's constitution.				
40.	6: Comply or explain	Council of governors	A.5.5	The chairperson is responsible for leadership of both the board and the council but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive to their meetings and inviting attendance by other executives and non-executives, as appropriate.
Provision 20 of the trust's constitution explains the arrangements in place for the trust.				
41.	6: Comply or explain	Council of governors	A.5.6	The council should establish a policy for engagement with the board of directors for those circumstances when they have concerns.
Provision 52 of the trust's constitution sets out provisions for disputes between the council of governors and board of directors.				

	Part of schedule A	Relating to	Code of Governance reference	Summary of requirement
42.	6: Comply or explain	Council of governors	A.5.7	The council should ensure its interaction and relationship with the board of directors is appropriate and effective.
The council of governors relies on several roles and functions to ensure its interaction and relationship with the board of directors is appropriate and effective. These include: the role of the trust chair as chairperson of both bodies; the role of the company secretary as adviser to both bodies; the work of the governor steering group and appointments committee; and the role of the governor representatives to the board of directors and its sub-committees. QVH has a long-standing practice of inviting a nominated representative of the council of governors, selected by the chair, to join the board as an ex officio, non-voting member. Some years ago the practice was extended to establish governor representatives to the main, non-statutory sub-committees of the board. These representatives are usually elected to the role by the council of governors. The role of governor representatives is appreciated by the trust as an established and effective means of open and honest engagement between governors and the board. Since the Health and Social Care Act 2012, the governor representative roles have become particularly significant as they play an important part in governors' duty to hold non-executive directors (NEDs) to account for the performance of the board. The roles foster closer working relationships between governors and NEDs and provide more opportunities for governors to see NEDs at work on a regular basis. As a result, governors are better able to appraise the performance of the NEDs and hold them to account. Following a review of board-level governance in 2015/16 the board of directors and council of governors agreed a document formalising principles of engagement between the council's governor representatives and the trust's board-level structures and mechanisms.				
43.	6: Comply or explain	Council of governors	A.5.8	The council should only exercise its power to remove the chairperson or any non-executive directors after exhausting all means of engagement with the board.
Not applicable in 2015/16. Paragraph 35 of the trust's constitution describes the process for removal of the chair and other non-executive directors.				
44.	6: Comply or explain	Council of governors	A.5.9	The council should receive and consider other appropriate information required to enable it to discharge its duties.
Compliant.				
45.	6: Comply or explain	Board	B.1.2	At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent
Compliant. The board of directors comprises a chairperson, four other non-executive directors, a chief executive and three other executive directors.				
46.	6: Comply or explain	Board, council of governors	B.1.3	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust.
Compliant. See provision 18 of the trust's constitution.				
47.	6: Comply or explain	Nomination committee	B.2.1	The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors.
Compliant.				
48.	6: Comply or explain	Board, council of governors	B.2.2	Directors on the board of directors and governors on the council should meet the 'fit and proper' persons test described in the provider licence.
In April 2015, in anticipation of the trust's next inspection by the Care Quality Commission and for the board to be assured of good governance processes with regard to declarations, the board of directors agreed to expand the trust's declaration of interests pro-forma for directors to incorporate a more formal fit and proper persons declaration. Declarations were made by all directors accordingly and each director submitted a self-assessment against the categories of person prevented from holding office. The director of HR conducted a review of documentation held on file for each director and other staff members of the board of directors to ensure compliance with the fit and proper persons test. In addition, insolvency checks and disqualified directors searches were undertaken for all board members who are also subject to disclosure and barring service checks every three years. In addition: • the director of HR and company secretary developed an integrated procedural document that describes the steps the trust takes to assure itself that its directors are fit and proper persons. This document formed part of the evidence required by the CQC to demonstrate that the trust meets the requirements of regulation 5: fit and proper persons: directors; and • the guidance documentation for directors on making both declarations of interest and fit and proper person declarations were amalgamated to better support the annual declarations process in future. Since the regulations were published, the Care Quality Commission has clarified that the regulations do not apply to governors except where a governor has a place on the board.				
49.	6: Comply or explain	Nomination committee	B.2.3	The nominations committee(s) should regularly review the structure, size and composition of the board and make recommendations for changes where appropriate.
Compliant.				

	Part of schedule A	Relating to	Code of Governance reference	Summary of requirement
50.	6: Comply or explain	Nomination committee	B.2.4	The chairperson or an independent non-executive director should chair the nominations committee(s).
Compliant.				
51.	6: Comply or explain	Nomination committee, council of governors	B.2.5	The governors should agree with the nominations committee a clear process for the nomination of a new chairperson and non-executive directors.
The appointments committee is a sub-committee of the council of governors. Part of its remit is to oversee the appointment processes for the chair and non-executive directors, making recommendations in this regard to the council of governors. In 2014/15, a search for a non-executive director was initiated on behalf of governors by the appointments committee using the services of executive search agency Odgers Berndtson. The candidate brief developed by Odgers in collaboration with the appointments committee was informed by an audit of existing non-executive directors undertaken by the trust chair. The audit clearly identified skills and experience in estates and information technology as priority criteria for the search. The search, selection and nomination process is described in detail in papers put to the council of governors on behalf of the appointments committee at the council meeting held on 9 April 2015. These papers are available from the QVH website at www.qvh.nhs.uk/for-members/public-meetings				
52.	6: Comply or explain	Nomination committee	B.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist of a majority of governors.
Compliant.				
53.	6: Comply or explain	Council of governors	B.2.7	When considering the appointment of non-executive directors, the council should take into account the views of the board and the nominations committee on the qualifications, skills and experience required for each position.
The appointments committee's terms of reference state that before any appointment is made by the council of governors, it should evaluate the balance of skills, knowledge and experience of the non-executive directors and, in light of this evaluation, prepare a description of the role and capabilities required for a particular appointment. In 2014 a skills audit of existing non-executive directors was undertaken by the chair designate to map skills to the trust's key strategic objectives and identify gaps. The results of the audit were used to develop and agree the candidate brief for the recruitment of a new non-executive director (see row 51 above).				
54.	6: Comply or explain	Council of governors	B.2.8	The annual report should describe the process followed by the council in relation to appointments of the chairperson and non-executive directors.
See row 51 above.				
55.	6: Comply or explain	Nomination committee	B.2.9	An independent external adviser should not be a member of or have a vote on the nominations committee(s).
Compliant.				
56.	6: Comply or explain	Board	B.3.3	The board should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity.
Not applicable.				
57.	6: Comply or explain	Board, council of governors	B.5.1	The board and the council governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make.
Compliant. Papers for meetings of the board of directors and council of governors are available from the trust's website. In addition to meeting papers, the board of directors and council of governors receive regular briefings from the trust, its regulators and its representative bodies to inform and provide context to the functions and decisions of the board and the council. The council of governors receives notification when papers for meetings of the board of directors are published and the meeting agenda and chief executive's report are extracted from the papers and issued directly to governors. Governors have a facility to log general queries to non-executive directors and the trust's executive management team. The log records the response to the queries so that they can be shared systematically with all governors to share information and learning across the council. In 2015/16 governor representatives to the board and its sub-committees were strongly encouraged to begin to submit personal reports to their colleagues in the company secretarial team's monthly newsletter for governors.				
58.	6: Comply or explain	Board	B.5.2	The board, and in particular non-executive directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis.
Compliant.				

	Part of schedule A	Relating to	Code of Governance reference	Summary of requirement
59.	6: Comply or explain	Board	B.5.3	The board should ensure that directors, especially non-executive directors, have access to independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors.
Compliant.				
60.	6: Comply or explain	Board, committees	B.5.4	Committees should be provided with sufficient resources to undertake their duties.
Compliant.				
61.	6: Comply or explain	Chair	B.6.3	The senior independent director should lead the performance evaluation of the chairperson.
The performance of the chair is assessed by the senior independent director in collaboration with the chair of the council of governors' appointments committee and taking into account feedback sought from directors and governors. See row 13 above.				
62.	6: Comply or explain	Chair	B.6.4	The chairperson, with assistance of the board secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as board members.
Compliant. In June 2015, the board of directors agreed a board development programme to ensure that it operates effectively and that the organisation is well led. The programme is the responsibility of the trust chair who is supported in this task by the director of human resources and organisational development and the company secretary.				
63.	6: Comply or explain	Chair, council of governors	B.6.5	Led by the chairperson, the council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities.
The collective performance of the council was assessed in 2015/16 in the context of the board-level governance review. Communication with members and the public on how the council has discharged its responsibilities was provided in two annual newsletters and regular email communication with members who have provided the trust with their email address.				
64.	6: Comply or explain	Council of governors	B.6.6	There should be a clear policy and a fair process, agreed and adopted by the council, for the removal from the council of any governor who consistently and *unjustifiably* fails to attend the meetings of the council or has an actual or potential conflict of interest which prevents the proper exercise of their duties.
The circumstances in which a governor may be disqualified or removed from the council of are set out in provision 18 of the trust's constitution.				
65.	6: Comply or explain	Board, remuneration committee	B.8.1	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.
Not applicable.				
66.	6: Comply or explain	Board	C.1.2	The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary. See also ARM paragraph 7.17.
See section 2.1 above.				
67.	6: Comply or explain	Board	C.1.3	At least annually and in a timely manner, the board should set out clearly its financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance.
Compliant. The trust publishes a summary annual plan on its website each year. Information on the trust's business and operation are published on the trust's website each month in the form of papers for meetings of the board of directors held in public. The trust publishes its annual report and quality and financial accounts each year and clinical outcomes data is published on the trust's website for each clinical specialty at appropriate intervals.				

	Part of schedule A	Relating to	Code of Governance reference	Summary of requirement
68.	6: Comply or explain	Board	C.1.3	a) The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS foundation trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS foundation trust. b) The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in: • the NHS foundation trust's financial condition; • the performance of its business; and/or • the NHS foundation trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS foundation trust.
Compliant.				
69.	6: Comply or explain	Board, audit committee	C.3.1	The board should establish an audit committee composed of at least three members who are all independent non-executive directors.
Compliant.				
70.	6: Comply or explain	Council of governors, audit committee	C.3.3	The council should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors.
Compliant. The council first approved the appointment of the trust's external auditors at its meeting held in public on 28 July 2011. The contract was made for a period of three years with an option to extend for a further two years. At its meeting in June 2014 the council of governors approved the audit committee's recommendation to reappoint KPMG as external auditors for one further year. At its meeting on 9 July 2015 the council of governors approved the audit committee's recommendation to reappoint KPMG as external auditors for another year. The council's considerations have been greatly assisted by the role of the governor representative to the audit committee and the incumbent's guidance to the wider council.				
71.	6: Comply or explain	Council of governors, audit committee	C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust.
The trust's external auditor was appointed in August 2011.				
72.	6: Comply or explain	Council of governors	C.3.7	When the council ends an external auditor's appointment in disputed circumstances, the chairperson should write to Monitor informing it of the reasons behind the decision.
Not applicable.				
73.	6: Comply or explain	Audit committee	C.3.8	The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.
In 2015/16, Mazars acted as providers of the trust's local counter fraud specialist service. An annual work plan was agreed and delivery was overseen by the audit committee. Counter fraud policies and procedures are widely publicised for staff and are included as part of the new staff induction process. Whistleblowing is the responsibility of the quality and governance committee. However, the audit committee is responsible for providing assurance that the whistleblowing process is fit for purpose and working effectively, as required by the board.				
74.	6: Comply or explain	Remuneration committee	D.1.1	Any performance-related elements of the remuneration of executive directors 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.
Compliant.				
75.	6: Comply or explain	Remuneration committee	D.1.2	Levels of remuneration for the chairperson and other non-executive directors should reflect the time commitment and responsibilities of their roles.
Compliant.				

	Part of schedule A	Relating to	Code of Governance reference	Summary of requirement
76.	6: Comply or explain	Remuneration committee	D.1.4	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.
Not applicable.				
77.	6: Comply or explain	Remuneration committee	D.2.2	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments.
Compliant.				
78.	6: Comply or explain	Council of governors, remuneration committee	D.2.3	The council should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.
Not applicable in 2015/16.				
79.	6: Comply or explain	Board	E.1.2	The board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums.
See row 11 above.				
80.	6: Comply or explain	Board	E.1.3	The chairperson should ensure that the views of governors and members are communicated to the board as a whole.
Responsibility for ensuring that the views of governors and members are communicated to the board as a whole is shared between the chair, the company secretary and the governor representative to the board of directors.				
81.	6: Comply or explain	Board	E.2.1	The board should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate.
Compliant. At its meeting held on 5 November 2015, the board of directors considered a report on the trust's co-operation with relevant third parties and was assured of the continued effectiveness of the following principles of co-operation: • The board of directors recognises that co-operation and collaboration are key to the sustainability of the organisation. • On behalf of the board, the executive management team and their direct reports are responsible for maintaining collaborative and productive relationships with representatives of third parties. They are supported by members of the clinical cabinet. • Third-party developments and opportunities are reviewed by the executive management team at its monthly meetings and take into account views and advice sought from the clinical cabinet and trust leadership forum. • Issues and risks are reported to the relevant groups/committees within the trust's governance structure and escalated to the board of directors for oversight and scrutiny.				
82.	6: Comply or explain	Board	E.2.2	The board should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each.
See row 81 above.				

3.5 Regulatory ratings

QVH has delivered a surplus of £813k for 2015/16. This represents strong performance against plan, particularly given historic and in-year cost pressures faced during the financial year.

Monitor, the independent regulator for NHS foundation trusts, assesses performance on a quarterly basis on two key measures as follows:

- Financial sustainability risk rating (FSRR). During 2015/16, Monitor changed the way it assessed financial performance and expanded the financial criteria to incorporate financial efficiency (underlying performance and variance from plan) in addition to the continuity of services measure. The FSRR is rated 1 to 4, where 1 represents the highest risk and 4 the lowest.
- Governance risk rating, classified as red or green.

QVH's performance against these measures in 2015/16 is set out below; in addition to data from the previous year for comparative purposes.

2015/16	Annual plan	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Financial sustainability risk rating	4	3	4	3	4
Governance risk rating	Green	Green	Green	Green	Green
2014/15	**Annual plan**	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
Continuity of services rating	4	4	4	4	4
Governance risk rating	Green	Green	Green	Green	Green

3.6 Statement of the chief executive's responsibilities as the accounting officer of Queen Victoria Hospital NHS Foundation Trust

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

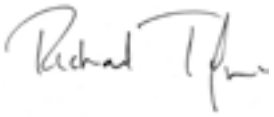
Under the NHS Act 2006, Monitor has directed Queen Victoria Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the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

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

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- prepare the financial statements on a going concern basis.

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

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



Richard Tyler
Chief Executive
23 May 2016

3.7 Annual governance statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Queen Victoria Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Queen Victoria Hospital NHS Foundation Trust for the year ended 31 March 2016 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Risk management is a corporate responsibility and the board of directors ensures that effective processes are in place to manage risk. The board is committed to the continuous development of a risk management framework focused on preventing harm to patients, staff and the public and to protect the trust from losses or damage to its reputation.

The director of nursing is the trust's lead for risk, supported by the head of risk. The trust's quality and governance committee (QGC) oversees the management of all areas of risk in the organisation. It is chaired by a non-executive director and its membership includes key directors and senior managers. At every meeting of the board of directors there is a detailed quality report which incorporates risk management and a report from the chair of the QGC to provide assurance about the risk management of care and services provided by the trust. The board assurance framework and the corporate risk register are also reviewed by the board at each of its meetings held in public to facilitate a detailed discussion about the level of risk, mitigating actions and any gaps or monitor controls to sustain and improve performance against essential standards of quality and safety. A director is responsible for each key strategic objective which incorporate risk management and mitigation.

The trust's risk management and incident reporting policy is available to all staff and provides clear instructions for identifying, reporting, investigating, managing and monitoring incidents and risks. All staff receive mandatory and - where required - bespoke training to facilitate risk management at all levels in the organisation. The trust is committed to empowering staff to meet the individual requirements of their role with regard to health and safety and risk management. Risk management training is also a mandatory requirement for all new staff joining the trust. The trust has a risk team that supports staff, facilitates an effective risk management processes and ensures learning from incidents is shared throughout the organisation.

Risks and incidents are collated using risk management software which provides effective reporting capability for the trust and individual teams and departments. Reviews of departmental risk registers and learning from incidents or near misses is shared with clinical leads and managers at monthly governance meetings. These forums are also used to escalate issues at departmental level. Immediate concerns are escalated directly to the head of risk who will review and refer to the director of nursing or medical director as required.

The risk and control framework

The trust's risk policy provides an outline of the risk processes and the ways in which a risk should be escalated. The trust's risk assessment tool includes a 5 x 5 matrix to determine the level of risk based on likelihood x consequence and ensures hazards, existing controls and further controls required can be clearly identified and documented. Any member of staff can identify and raise a risk by speaking to their line manager or logging this on the risk management software. Staff are encouraged to consider the wide variety of circumstances/sources in which risks can occur or be identified such as incidents, audits, external reviews, inspections and service reviews.

Risks are recorded on a risk management software package designed to store information on risks, incidents, complaints, claims, CQC standards and freedom of information requests. The software allows risks, incidents complaints and claims to be linked and interpreted to look for trends and areas of concern. This system is managed by the risk team.

Identified risks are classed as departmental or corporate. Departmental risks are managed by the clinical lead and/or manager within the department to ensure staff are aware of potential hazards within their working practice and that mitigating actions are in place. Corporate risks may be from escalated departmental risks scored at 12 or more, or are risks affecting the whole trust requiring input and monitoring from directorates and groups within the corporate governance structure. The trust's risk appetite is based on the level of risk and the authority a manager or committee has in managing it. High-level risks (major and catastrophic rated 12-25) are escalated to the clinical governance group, QGC and board of directors. If adequate controls cannot be put in place to treat the risk a decision will be made to terminate, transfer or accept the risk. Each risk is categorised in the system under one of the following headings:

- Patient safety
- Staff safety
- Estates infrastructure and environment
- Information governance
- Compliance (targets, assessments, standards)
- Finance.

All risks rated 12 and above are reviewed and monitored on a monthly basis by the QGC to ensure actions are completed within the required timescale and to provide assurance that learning has been shared within relevant teams or beyond. At every meeting of the board of directors there is a detailed quality report which includes a risk management section and a report from the chair of the QGC to provide assurance about risk management. The board assurance framework (BAF) and the corporate risk register are also reviewed at each meeting of the board held in public to facilitate a detailed discussion about how the risk has been managed and how to address any gaps or monitor controls.

In 2015/16 the board redesigned its BAF to better articulate and track the key risks to the trust achieving its key strategic objectives. A brief summary of the key strategic objectives, the associated risks and mitigating action is provided on page 47 opposite:

KEY STRATEGIC OBJECTIVE	RISKS	MITIGATION
Outstanding patient experience	• Failure to recruit and retain the right workforce. • Loss of confidence in the quality of services and the environment in which we provide them, due to the condition and fabric of the estate.	• Bespoke specialty recruitment days. Senior leadership to support nursing revalidation. • Development of full estates strategy, programme of maintenance and remedial work in progress.
World class clinical services	• Loss of confidence in trust services due to a lack of published outcomes, reduction in research outputs and fall in teaching standards. • Delivery of required clinical governance standards.	• Investment in posts to support quality, compliance, audit and research. • Focus on placement experience and improved supervision for trainees. • Demonstrating compliance with CQC essential standards. • Plans to audit 20% of applicable NICE clinical guidelines and quality standards. • Out-of-hours review of medical workforce.
Operational excellence	• Loss of confidence in ability to provide timely and effective treatment due to increase in waiting times and/or fall in productivity.	• Review of access to trust services, new patient access manager appointed. • Monthly performance review and reporting to finance and performance committee.
Financial sustainability	• Loss of confidence in long-term financial sustainability due to failure to create adequate surpluses to fund operational and strategic investments.	• Robust contract monitoring and monthly performance review. • Development of achievable and sustainable cost improvement plan. • Enhanced budget setting and business planning. • Structure, systems and process redesign and enhanced cost control.
Organisational excellence	• Loss of staff confidence in the trust as place of choice to work and a good employer.	• Three-year workforce plan for 2016/17. • New leadership programme, board approved staff survey action plan. • Support for staff education.

The corporate risk register details in-year risks, highlights any that threaten achievement of the key strategic objectives and links to the BAF. The BAF is based upon the *QVH 2020* key strategic objectives which are part of the trust's longer term plan. Each risk is the responsibility of a named director and a named lead responsible for delivering the actions. Progress and outcomes are managed by the QGC. The BAF is discussed at key strategic objective level at every meeting of the board of directors held in public.

The audit committee seeks additional assurance on risk management by commissioning internal and external audits as part of the audit work programme or in response to specific issues. The board follows the principles of the Monitor quality governance framework in assessing and determining the assurances required and designing the audit work programme.

The trust monitors compliance with its provider license by several means, including:

- The board assurance framework
- Routine performance reports to the board of directors and its sub-committees
- Routine monitoring calls with the trust's relationship team at Monitor
- Scrutiny and advice of the company secretary and wider executive management team.

Risk management is embedded within the activity of the organisation in many ways. For example, risk management is included within each departmental meeting agenda and existing risks are discussed along with the identification of new risks. Data security is described in the information governance section below. Learning from incidents is integral to the risk process and is shared at a variety of forums and groups including the clinical governance group, QGC, staff briefings, risk newsletter, trust leadership forum, joint hospital governance meeting and clinical cabinet. The clinical governance group monitors all clinical incidents to ensure correct action and learning has taken place. Examples of changes as a result of the learning in 2015/16 include changes in clinical practice, bespoke training sessions and

changes to trust policy. Equality and human rights impact assessments are also completed for each of the trust's policies prior to final ratification.

Public stakeholders are involved in managing risk through the risks identified by external assessors, incidents, complaints and other external bodies. The council of governors receives quarterly updates about quality and risk from the non-executive chair of the QGC and from the governor representative to the QGC.

The trust is fully compliant with the registration requirements of the Care Quality Commission (CQC) following a full inspection and unannounced follow-up visit during November 2015. The trust was rated overall as 'good' and care quality was rated 'outstanding'. The recommendations from the CQC have been transferred into an action plan agreed by the board and monitored by the QGC. The director of nursing is the executive lead for this work.

As an employer with staff entitled to membership of the NHS pension scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Equality Duty came into force on 5 April 2011. It ensures that public bodies consider the needs of all individuals in their day-to-day work, for example in shaping policy, delivering services and in relation to their own employees. Compliance with this duty includes the publication of the QVH workforce race equality standard which demonstrates the progress being made towards the nine nationally-specified equality metrics (e.g. percentage of staff believing the trust provides equal opportunities for career progression or promotion). In addition, QVH has developed a new equality and diversity strategy and associated action plan which will be presented to the board of directors in May 2016. The strategy has been aligned to the EDS2 which is a public commitment of how NHS organisations plan to meet the needs and wishes of local people and staff, and meet the duties placed on them by the Equality Act 2010. It also sets out how they recognise the differences between people and how they aim to make sure that any gaps and inequalities are identified and addressed. The equality and diversity strategy is aimed at ensuring that the trust meets this commitment and demonstrates real progress in promoting equality.

The strategy sets out our equality and diversity objectives for the next three years to ensure we maintain high standards of employment practice across the trust. Regular monitoring of progress is carried out by the equality and diversity group which comprises governors and a broad range of staff from across the organisation. In 2015/16 QVH has increased to eight the number of equality champions who help to promote equal opportunities within the services we provide.

The foundation trust has undertaken risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

The trust ensures economy, efficiency and effectiveness in a number of ways from robust planning and application of controls to performance monitoring and independent reviews.

Each year, the financial plan is approved by the board and submitted to Monitor. In 2015/16 the trust board agreed to constitute a new committee with the purpose of assuring the board that financial and operational plans were robust, on target to deliver on time and make the agreed contribution to the trust's overarching key strategic objectives. As such, the plan, including forecast projections, performance indicators and monitor metrics, is now monitored by the finance and performance committee on a monthly basis. In addition, the board of directors receives performance reports, minutes from the committee and matters for escalation.

The trust's resources are managed within the framework of its primary governing documents including standing orders and standing financial instructions. Financial governance arrangements are supported by internal and external audit to ensure economic, efficient and effective use of resources. The trust has an annual programme of internal audit and the audit committee monitors progress against the programme and implementation of recommendations identified and agreed as part of the audit fieldwork.

With respect to internal audit, there have been a number of financial reviews spanning all aspects of financial control, processes and reporting. Of the audits undertaken, the outcome received was substantial assurance for four reviews and full assurance for one.

Business units and corporate directorates are responsible for the delivery of financial and other performance targets. In 2015/16 performance management has been enhanced to include an executive lead review and an integrated approach that aligns the delivery of clinical and non-clinical operational targets, quality indicators and financial measures.

Information governance

Responsibility for the information governance agenda is delegated from the chief executive to the senior information risk owner (SIRO), who is the director of finance. The SIRO is responsible for ensuring that information risk management processes are in place and are operating effectively.

The information governance group (IGG) is chaired by the SIRO and is responsible for overseeing the trust's information governance arrangements and compliance against required standards and targets. The group, which includes representation from across the trust, reports to the executive management team for oversight and scrutiny and to the quality and governance committee for assurance purposes.

One of the key responsibilities of the IGG is to oversee the trust's annual information governance toolkit assessment. The toolkit is an online system which allows NHS organisations to assess themselves against relevant policies and standards. For 2015/16, the overall assessment score was 77% and graded green (satisfactory). In addition, an internal audit of information governance arrangements detailed an outcome of substantial assurance but did note a series of recommendations that once implemented will support and improve performance.

All staff and volunteers are mandated to undertake information governance training on an annual basis. During 2015/16 there has been a targeted action plan, delivered and supported through the IGG, to increase awareness of responsibilities in relation to safeguarding confidentiality, protecting data and preserving information security, additional training sessions on the achievement of compliance targets and a review and update of all associated policies.

Information security risks are managed and controlled via the risk management system, incorporated into the risk register and reviewed by the IGG.

There were no serious incidents that were classified as a level 2 relating to information governance in 2015/16.

Annual quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare quality accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports which incorporate the above legal requirements in the *NHS Foundation Trust Reporting Manual*.

In response to the limited assurance opinion from last year's quality report, the trust prioritised the appointment of a patient access and performance manager to lead a review and redesign of 18-week referral to treatment and 62-day cancer waits. This work commenced in the third quarter of 2015/16 and was refined in the fourth quarter of 2015/16. This work included the review and redesign of the cancer patient tracking list, a refresh of systems and processes to track and validate patients and the training offered to staff. This led to a substantial improvement in data quality in-year. But the absence of the complete 2015/16 data set resulted in a limited assurance opinion from the external auditors, as the trust had expected. Work therefore continues in regard to these standards.

The separate issue of data quality at our spoke sites presents a different challenge to QVH. Work is underway to improve the quality of all externally supplied data. A solution has been identified and implementation will commence in quarter two of 2016/17. Whilst we are confident that this will lead to a significant improvement in data quality the absence of a full year's data will result in the external auditors being unable to give QVH an unqualified opinion for 2016/17.

QVH has prepared its quality accounts with strong clinical and managerial input including:

- Quarterly updates to the trust's quality and governance committee on progress against quality priorities chosen for the quality account 2015/16
- Members of the clinical cabinet and the board of directors receive monthly performance reports on quality metrics (including infection control rates, referral to treatment performance, cancer waits, and patient experience measures)

- National statutory data collected from external sources, which enables benchmarking and comparison with peers
- Specialty data compiled in conjunction with clinical directors and lead clinicians
- Specialty information/audit and national audit outcome data received by the clinical governance group
- External audit commissioned before submission to ensure data accuracy and validity.

Review of effectiveness

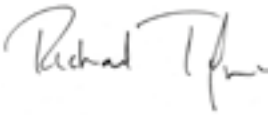
As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and the quality and governance committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process for maintaining and reviewing the effectiveness of the system of internal controls includes:

- Regular board review of the board assurance framework and risk registers, as well as regular assurance reports by the chairs of the two key board assurance sub-committees (finance and performance and quality and governance) and minutes from audit committee meetings. Key risks are fully debated and the board ensures actions are in place where necessary.
- Board members receive monthly performance reports on:
  - » safe staffing and quality of care
  - » operational performance
  - » financial performance
  - » workforce.
- The board receives regular information governance reports.
- The audit committee reviews findings from internal and external audit work and ensures links to the risk register and assurance framework are maintained.
- The head of internal audit opinion has given a 'significant assurance' rating on the effectiveness of the systems of internal control.
- The quality and governance committee reviews feedback from external assessments on quality of service, including CQC, NHSLA and audit, as well as ensuring internal quality measures are regularly tested and standards are met.

Conclusion

The trust has continued to provide high quality services for its patients and to meet the needs of its various regulators. The review of governance and controls confirms that the trust has managed risks effectively through the year and can provide assurance that effective systems are in place to support the running of the organisation. I am pleased to conclude that at the end of the year there are no significant internal control issues for the trust.



Richard Tyler
Chief Executive
23 May 2016

4

Quality report

"Our vision is based on the straightforward belief that continually striving to deliver excellence is the most effective way of ensuring that QVH continues to thrive."

Statement on quality

QVH 2020: Delivering Excellence is our shared vision for continued success at QVH over the coming years. It is based on the straightforward belief that continually striving to deliver excellence is the most effective way of ensuring that QVH continues to thrive.

As a trust we were therefore very pleased with the overall 'good' rating we received from the CQC and particularly proud to be rated 'outstanding' for patient care. This is a testament to our commitment to providing expert and compassionate care and to our values of humanity, pride and continuous improvement.

Maintaining high quality services relies upon continual day-to-day improvements alongside longer-term strategic developments. In 2015/16 we made good progress against our quality priorities with steady improvements in patient food and the expansion of trauma capacity. In addition, we have been supporting broader improvements across the health service as a whole with increased research output and greater numbers of patients taking part in research studies.

"We were very pleased with the overall 'good' rating we received from the CQC and particularly proud to be rated 'outstanding' for patient care."

Quality improvements have been underpinned by our clinical governance systems and processes, both of which are fundamental to the delivery of high quality care. During the year, we undertook an extensive review of these systems, leading to considerable improvements.

Looking to the future, I am confident that we have the necessary priorities, processes and plans in place to further improve our patients' care and hospital experience as we continue striving to deliver excellence.

I certify to the best of my knowledge that the information in this document is correct.

Richard Tyler
Chief Executive

Priorities for improvement

QVH's quality priorities for 2016/17

Priorities for 2016/17 have been influenced by progress on our 2015/16 priorities and patient feedback. They have been developed in collaboration with all staff, the council of governors and our lead clinical commissioning group through their contributions to our long-term strategic plan.

Priorities are built around our ambitions and intention to deliver safe, reliable and compassionate care in a transparent and measurable way.

Each priority relates to one of the three core areas of quality:

Patient safety

Having the right systems and staff in place to minimise the risk of harm to our patients and, if things do go wrong, to be open and learn from our mistakes.

Clinical effectiveness

Providing high quality care, with world-class outcomes, whilst being efficient and cost effective.

Patient experience

Meeting our patients' emotional as well as physical needs.

Our clinical priorities and why we chose them	What success will look like
Patient safety	
Reduce the investigation time for incidents from the current average of 60 days to 30 days, in line with national targets to improve safety and learning from incidents We want to improve the time taken to report all incidents to the National Reporting and Learning Service (NRLS) by decreasing the number of days it takes us to do this.	QVH has set local targets to exceed the national recommendation of investigating incidents within 30 days. Incidents categorised as 'no harm', 'near miss' and 'minor harm' will be reported consistently within 10 working days in 90% of cases. Those incidents causing 'moderate', 'major' and 'catastrophic harm' will be reported within 20 working days in 80% of cases.
Clinical effectiveness	
Proactive audit of compliance with 20% of applicable NICE clinical guidelines and quality standards QVH is committed to ensuring that services take into account national guidance and embed the latest evidence-based practice into the care and treatment of our patients. We have chosen to review and audit compliance with 20% of our key National Institute for Health and Care Excellence (NICE) guidelines to measure compliance with their recommendations and identify any areas that require focussed attention or improvement. Guidance for auditing has been prioritised following a review by the medical director, director of nursing and the head of quality and compliance.	From 2001 until March 2016, NICE has published 21 quality standards and 44 clinical guidelines relevant to services provided by QVH. Clinical audit projects will be completed for a minimum of 20% of these quality standards and clinical guidelines.
Patient experience	
Improve signage and walkways While patients tell us that the standard of care they receive across our services is very high, and they praise staff for the kindness and compassion they receive, some patients comment that they have difficulty finding departments and navigating the site. We have chosen to make it a priority to improve wayfinding for patients and visitors.	By the end of quarter 2, improvements to the covered walkway surfaces will have started. In addition to resurfacing, we will ensure that the walkways meet dementia standards. We will remove obsolete signs and put up new signage as appropriate. In addition, a wayfinding strategy will be included within the estates improvement plan and any future estates developments will include wayfinding options.

Performance against 2015/16 priorities

Priorities for 2015/16 were influenced by information from national and local reports and audit findings along with the views of governors, the programme board (which includes representation from Crawley and Horsham and Mid Sussex CCGs), our lead clinical commissioning group, patient feedback and suggestions from staff across the organisation.

End of year progress against our three 2015/16 qualities priorities was as follows:

1. Scheduling of elective surgery

We aimed to increase the percentage of elective patients booked with at least three weeks' notice to ensure they had time to plan their personal commitments accordingly. We have not achieved the target for this priority, although there has been considerable work to improve the management of activity and on the application of the access policy.

Patients are treated in clinical priority and strict date order, both of which are key quality issues. However, during the past year, the trust has worked to ensure that any bookings cancelled are fully utilised as far as possible. It is not uncommon for patients to ask to cancel or reschedule at relatively short notice for a variety of reasons. When a patient cancels or reschedules at short notice, or is too unwell for surgery, we offer these short-notice appointments to other patients. While this is effective booking management, it will mean that these patients are given less than three weeks' notice. Patients are placed under no pressure to take a short-notice booking and many patients are happy to take up this offer.

In order to improve efficiency and patient experience we have also piloted a new way of booking some skin patients in the outpatients department. We offered patients a date for surgery at their outpatient appointment, starting with the first available slot. Some patients chose dates for surgery that gave less than three weeks' notice because this best met their needs. This was a popular and successful initiative and will be rolled out across other specialties during 2016/17 along with patient surveys to ensure we capture feedback on this offer. We have not met our original objectives for this priority but believe that the actions we have taken during the year have significantly improved patient experience.

Percentage of elective patients booked with at least three weeks' notice 2015/16

Month	Target	Actual
Apr 15	50%	53%
May 15	50%	55%
Jun 15	50%	54%
Jul 15	60%	55%
Aug 15	60%	60%
Sep 15	60%	60%
Oct 15	60%	48%
Nov 15	70%	49%
Dec 15	70%	46%
Jan 16	80%	59%
Feb 16	80%	57%
Mar 16	80%	58%

"Some patients chose dates for surgery that gave less than three weeks' notice because this best met their needs. We believe that the actions we have taken during the year have significantly improved patient experience."

2. Expansion of trauma capacity

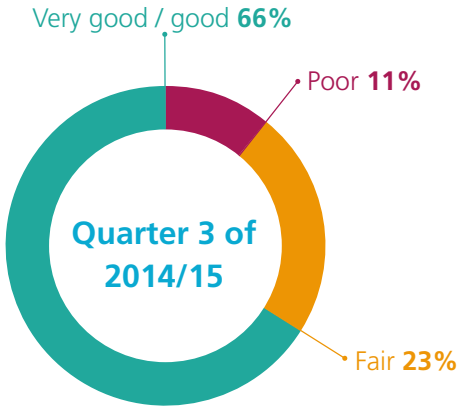
We aimed to increase capacity for trauma surgery so that 90% of patients would have their trauma surgery within 24 hours of admission. QVH began to offer additional capacity for trauma surgery from June and this was expanded further from September.

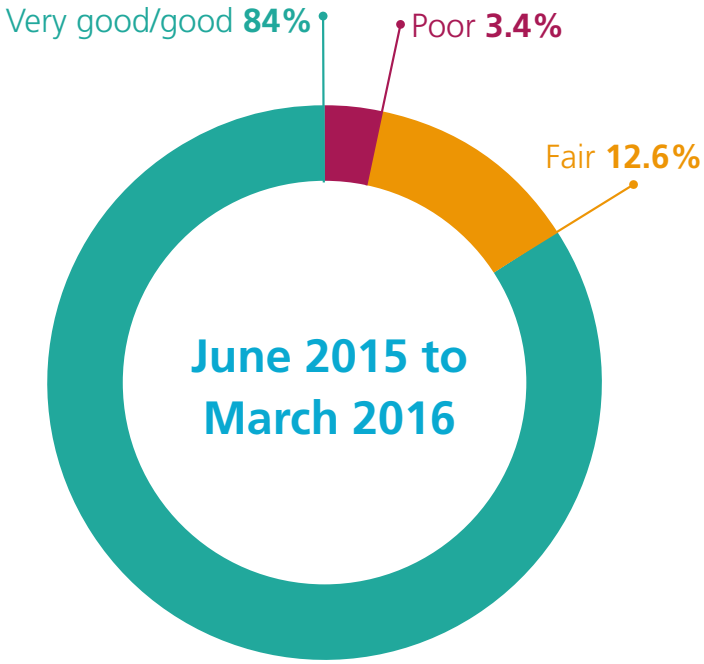
The number of trauma patients treated within 24 hours of admission improved from 85% in quarter 2 to 89% in quarter 3 but decreased slightly to 86% in quarter 4, just below the 90% target. In part this is due to the relatively small number of trauma operations having an impact upon the percentage.

We are continually looking at ways to improve and one initiative has been to enhance how we use the theatre co-ordinator role with the trauma team to improve communication and flow through theatre so patients can begin their surgery sooner.

Percentage of trauma patients undergoing first trauma surgery within 24 hours of admission

Month	Target	Actual
Apr 15	90%	90%
May 15	90%	79%
Jun 15	90%	81%
Jul 15	90%	82%
Aug 15	90%	87%
Sep 15	90%	86%
Oct 15	90%	87%
Nov 15	90%	88%
Dec 15	90%	92%
Jan 16	92%	86%
Feb 16	92%	85%
Mar 16	92%	88%





3. Improving patient experience of QVH food

We aimed to improve our patients' experience of QVH food as measured by the NHS friends and family test surveys. There has been steady progress on this throughout the year.

A detailed plan led by the head chef has improved the menu, the presentation of the food and the food temperature. A food task and finish group led by a matron and chaired by one of our public governors has concluded. As a result of this, new menus, new ways of serving food, new crockery and better communication between clinical areas and the kitchens have been introduced.

Our baseline in quarter 3 of 2014/15 was 34% of patients rating their food as 'fair' or 'poor' (of these 11% rated it as 'poor'). Our target for quarter 4 of 2015/16 was to have 'fair' or 'poor' ratings at 20% or less with 'poor' ratings not greater than 5%.

We achieved this target, with average ratings from June 2015 to March 2016 of 16% for 'fair' or 'poor' and only 3.4% 'poor'. Anecdotally, negative comments and complaints about the food from patients and relatives received on regular ward rounds by the director of nursing have significantly reduced and there are now occasional plaudits about the food.

Sign up to Safety campaign

Sign up to Safety is a national initiative led by NHS England to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest way possible. Its mission is to strengthen patient safety in the NHS and make it the safest healthcare system in the world.

During the year we have been working to reduce avoidable harm in the NHS by progressing our local adaptation of the Manchester Patient Safety Framework (MaPSaF) - a tool to help NHS organisations assess their progress in developing a safety culture - designing it to cover aspects such as medication errors and pressure damage. This adaptation of the tool will be completed during 2016 so that implementation can begin.

We have also put in place a number of improvements to our risk management processes. For example, within incident reporting, the trust's electronic system is now aligned to meet the Duty of Candour requirements, supplemented by an audit.

We also undertake detailed monitoring of incident reporting by staff and are working to reduce investigation timescales with a target of completing investigations within 30 days for all incidents. Incidents, risks, claims, complaints and audits are now triangulated, with information fed into monthly performance monitoring meetings.

We have enhanced the support available for staff and the identification and dissemination of learning with the creation of a new Datix (our incident reporting system) users forum, additional risk management training and the development of a regular patient safety newsletter for staff. Learning aspects are discussed at a range of forums across the trust and at morbidity and mortality meetings.

Our Sign up to Safety pledges can be viewed on our website. Collectively, they are one of our local Commissioning for Quality and Innovation (CQUIN) targets for 2016/17.

Duty of Candour

The Duty of Candour is a legal duty on NHS trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. It aims to ensure that patients receive accurate, truthful information from health providers.

QVH promotes a culture that encourages candour, openness and honesty at all levels. It is an integral part of our culture of safety, which also supports organisational and personal learning. The board is committed to openness and transparency at all levels across QVH.

We have always been committed to being open and honest with patients and have undertaken a number of initiatives to ensure that we are effective in embedding the Duty of Candour into our systems and processes, including:

- Our electronic incident reporting system is now aligned to the Duty of Candour to ensure that appropriate incidents are captured and the relevant healthcare professionals are notified that an incident has occurred so the necessary investigations can be undertaken.
- A patient information leaflet has been created to inform patients of what to expect and their rights if harm does occur.
- A programme of ongoing staff training has been established and will continue during 2016/17 to enable staff to support our patients effectively.

Patient safety achievements

2015/16 achievements	Further work for 2016/17
Safety standards for invasive procedures The introduction of the national and local safety standards for invasive procedures (NatSSIPs and LocSSIPs) has led QVH to build upon its work in 2015 to adapt, pilot and introduce the WHO surgical safety checklist to minimise risks and improve safety for patients undergoing minor procedures. We will continue to progress this work towards the September 2016 deadline.	We will continue to implement the standards in 2016/17 by reviewing current processes and ways of working to ensure the standards are embedded into practice. The standards will also be monitored and audited to ensure they continue to be embedded in the correct way to benefit patients. We will also continue in engage with other healthcare organisations and partners to share learning and our experiences of using these standards.
Identification and treatment of sepsis Sepsis is a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs. It can lead to shock, multiple organ failure and death, especially if not recognised early and treated promptly. Globally, sepsis remains the primary cause of death from infection despite advances in treatment and monitoring. QVH has introduced a new sepsis policy and pathway for use within the trust.	We will continue to screen all appropriate patients and initiate rapid treatment where required. We intend to measure our performance on a sample of cases against the NICE clinical guideline for sepsis management due to be released in July 2016.
'Human factors' training QVH has implemented a programme of human factors training with funding support from Health Education Kent, Surrey and Sussex. The aims are to help healthcare professionals to understand why errors are made; the 'systems factors' that can impact on patient safety; and to raise awareness of how their own attitudes and behaviours and those of others can be used to develop teams and improve the quality and safety of patient care. Human factors training has been specifically targeted at operating theatre staff. Alongside dedicated human factors training, QVH medical staff have led multi-disciplinary simulation training which pays heed to the human factors knowledge and skills required to function safely and effectively as individuals and a team.	We will further integrate human factors tools and methodologies into root cause analysis and incident investigations across the trust, to help improve the identification of errors and facilitate continuous learning.

Clinical effectiveness achievements

2015/16 achievements	Further work for 2016/17
Enhanced recovery after breast surgery QVH is continually seeking new and innovative ways to improve the experience and wellbeing of patients undergoing major surgery. The breast team has produced a multi-disciplinary Enhanced Recovery After Surgery (ERAS) guideline and pathway. Patients are actively encouraged to be aware of and participate in steps to improve the outcomes from their surgery. The aims of the ERAS pathway are to improve the quality of care and enhance the patient experience. The guideline and pathway ensure that patients receive consistent, evidence-based medicine to optimise the quality of care and return to normal life as quickly as possible after surgery.	An award-winning early audit of outcomes from the ERAS programme has shown some promising improvements and highlighted areas for future development. The breast team gathers data on a regular basis to assess the effectiveness of the pathway and learning is also used to inform other ERAS initiatives within QVH. The service will continue to work in conjunction with other centres to help build knowledge and understanding of ERAS for breast patients and further develop the pathway as necessary.
Enhanced recovery after head and neck surgery The QVH Enhanced Recovery Programme for Head and Neck Surgical Patients (ERPHN) aims to reduce the physical trauma of surgery. It is a collection of strategies in a structured pathway that supports the multidisciplinary team (surgical, anaesthesia, allied health professionals and ward staff) to work together to optimise patient outcomes, including early discharge where appropriate.	The use of this pathway and the benefits for patients will continue to be publicised. An audit will also be carried out to ensure the effectiveness of the pathway and to review its impact on patient care.
Sentinel node biopsy Sentinel node biopsy is a procedure in which the sentinel lymph node is removed and examined under a microscope to determine whether cancer cells are present. It is based on the idea that cancer cells spread (metastasize) in an orderly way from the primary tumour to the sentinel lymph nodes, then to other nearby lymph nodes. Radiolabelled sentinel node biopsy was first introduced to QVH in 2014/15 to assist in diagnosis and treatment of patients with breast cancer. This work required the complex interplay of specialities including breast and plastic surgery, operating theatres, medical physics and diagnostic imaging at remote sites to coordinate labelling with surgery. The effort required is justified by the improved quality of diagnosis and treatment offered.	Having already introduced radiolabelled sentinel node biopsy for breast surgery, QVH is now implementing this procedure for head and neck cancer. This will be conducted in accordance with NICE clinical guideline NG14, against which we will measure our services. In addition, as a separate piece of work, we are an indicator site for NICE to assess some of the challenges and learning from introducing their new guidelines into practice.

2015/16 achievements	Further work for 2016/17
Tracheostomy training QVH has devised a rolling programme of multi-disciplinary training for staff treating our complex head and neck patients. It meets the recommendations of the National Confidential Enquiry into Patient Outcome and Death's 2014 report *On the Right Trach? A review of the care received by patients who underwent a tracheostomy.* This training programme supports healthcare professionals to deliver the ERPHN.	The ongoing programme of training will continue, to ensure that healthcare professionals have the necessary knowledge and skills to provide the best care for patients.
Laryngectomy training QVH is a surgical centre for head and neck patients, a small patient group requiring highly specialised multidisciplinary care. We endeavour to continually broaden our knowledge and awareness of this patient group and a programme of ongoing laryngectomy training was formulated to support the teams caring for these patients. This training builds on the care provided by the ERPHN.	The training will continue, to further develop and widen the knowledge of the multidisciplinary team looking after this patient group and to increase awareness of the care they require.
Clinical electroporation We are well advanced in developing our patient pathways and staff training to enable us to commence electrochemotherapy treatment to skin nodules of the head and neck, with the business case and policy already approved. This new NICE approved treatment combines a low dose chemotherapy drug and an electrical pulse applied directly to the cancer cells. This allows more of the cancer drug to enter the cells with a dramatic increase in the effectiveness of treatment.	We will be updating the electrochemotherapy policy in May 2016 prior to commencing treatment of patients in the summer of 2016. We anticipate this service will also be rolled out to advanced melanoma and metastatic breast cancer patients in the future.

Patient experience achievements

2015/16 achievements	Further work for 2016/17
Butterfly Scheme for dementia patients In 2013, QVH introduced the Butterfly Scheme which empowers people with dementia and their carers to choose the care they want. Patients with a diagnosis of dementia or memory impairment, assisted by their carer, can choose to use a butterfly symbol to request dementia-specific care. During 2015/16 QVH has implemented its dementia strategy and all staff working in clinical areas have been taught essential skills to allow them to care well for these patients. The Butterfly Scheme is led by our dementia champions - staff with a particular interest in improving the care, support and experience for people with dementia. QVH has also signed up to John's Campaign, a UK-wide campaign for the rights of people with dementia to have their carers with them if they are admitted to hospital.	We will continue to focus on providing individualised care for people with dementia and their carers. We will continue to monitor a wide range of data and feedback to assess how well we are caring for these patients and to help us to make improvements where needed. John's Campaign has also been included as a CQUIN target for 2016/17. It will further develop a positive culture of knowledge, understanding and empathy across all staff groups.

"Patients with a diagnosis of dementia or memory impairment, assisted by their carer, can choose to use a butterfly symbol to request dementia-specific care."

2015/16 achievements	Further work for 2016/17
#hellomynameis Since January 2015, QVH has been signed up to the #hellomynameis campaign which was started by Dr Kate Granger, a terminally ill cancer patient. Kate observed that many staff did not introduce themselves before delivering care and thought that this should be a basic step in communication with patients. At QVH we pride ourselves on delivering a warm welcome to our patients and patient-facing staff have been given badges with their names on to facilitate interaction with patients and support the campaign.	Work on the campaign will continue in 2016/17 and badges will be rolled out to administrative and support service staff.
CREW camp for paediatric patients CREW (challenging, recreational, educational weekend) is a unique support programme for up to 30 paediatric patients who have experienced burns injuries. A charitable initiative in collaboration with the community, it offers these patients an opportunity to meet others, share experiences and improve self-esteem. The focus on physical challenges is based on evidence that if young people with scars - who may not feel good about how their bodies look - feel good about what their bodies can do, they can develop a better body image and higher self-esteem.	We will continue to work with the local community to secure funding so that this initiative can continue.
Improved patient experience of food Historically, patient feedback indicated that QVH food was not meeting the expected standards and this was made a quality priority for 2015/16. A task and finish group led by a matron and a public governor and reporting to the patient experience group resulted in the implementation of a number of initiatives, including: • A red tray system to indicate patients who require help with feeding • New crockery to support patients with dementia • New weekly menus • New food trolleys that better maintain temperature and hold more food choices.	We will continue to monitor satisfaction with food through patient surveys and benchmarking against our peers. The trust's nutrition nurse will undertake an additional inpatient food survey in conjunction with dietetics and matrons and seasonal menus will be audited bi-annually.
New patient and visitor lounge During 2015/16, QVH opened the Lancaster Lounge, a new coffee lounge and eating area for patients and visitors. Situated in Canadian Wing, it was generously funded by the QVH League of Friends. RAF nurses based at QVH also raised the necessary funds to refurbish the military plaques that hang beside the Guinea Pig Club roll of honour opposite the entrance to the new lounge.	We will continue to monitor feedback to ensure that the Lancaster Lounge and our other facilities for patients and visitors continue to meet their needs.

Statements of assurance from the board

Review of services

During 2015/16, Queen Victoria Hospital NHS Foundation Trust provided 20 NHS services including burns care, general plastic surgery, head and neck surgery, maxillofacial surgery, corneoplastic surgery and community and rehabilitation services. QVH has reviewed all the data available to it on the quality of care in all of its NHS services. The income generated by the relevant health services reviewed in 2015/16 represents 90% of the total income generated from the provision of relevant health services by QVH for 2015/16.

"Research sits at the heart of the trust's vision. Participation in research helps our staff stay abreast of the latest treatment possibilities and enables us to deliver improved patient outcomes."

Research

Research sits at the heart of the trust's vision. Pioneering techniques developed at QVH in the past are now used routinely in the care of patients all over the world, for example, burns reconstructive surgery, cell culture and hypotensive anaesthesia. Our current research programme focusses on developing techniques in the area of wound healing and reconstruction. We are proud to be holders of NIHR RfPB, NIHR i4i, MRC and Wellcome grants and believe that this reflects the quality of our research.

We have a joint appointment with the University of Brighton at the grade of senior lecturer. This post has been instrumental in strengthening our relationships with our key academic partners including the University of Brighton, Brighton and Sussex Medical School and the Blond McIndoe Research Foundation. Wide networks are critical to successful research investment and outputs, especially in the specialised fields of practice of QVH. We are seeking to build closer ties to the excellent facilities, expertise and resources available on-site at the Blond McIndoe Research Foundation and expect this relationship to develop over the coming year. The two organisations are well placed to link together into the work of specialised centres at national and even international level.

The total number of participants that were recruited to research studies approved by a research ethics committee in 2015/16 was 375, with QVH taking part in 32 studies. Our participation in research demonstrates our continued commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Participation helps our clinical staff to stay abreast of the latest treatment possibilities and enables us to deliver improved patient outcomes.

Participation in clinical audits and clinical outcome review programmes

A clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes.

During 2015/16, three national clinical audits and three clinical outcome review programmes (previously known as confidential enquiries) covered relevant health services that QVH provides.

We participated in 100% of national clinical audits and 100% of clinical outcome review programmes that we were eligible to participate in. The tables below also include the percentage of registered cases required by the terms of that audit or review programme.

Participation	✓ Yes	✗ No	**% of cases submitted**	100% Percentage	ND No data - figure unavailable as audit ongoing

Participation in national clinical audits 2015/16

National audit of non-melanoma skin cancer excision	Rheumatoid and early inflammatory arthritis	UK flap registry
✓ ND	✓ 100%	✓ ND

Participation in clinical outcome review programmes 2015/16

Gastrointestinal haemorrhage (NCEPOD*)	Sepsis (NCEPOD*)	Care of patients with mental health problems in acute general hospitals (NCEPOD*)
✓ 100%	✓ 100%	✓ 100%

* National confidential enquiry into patient outcome and death

Three national clinical audits were reviewed by QVH in 2015/16 and we intend to take the following actions to improve the quality of healthcare provided:

Rheumatoid and early inflammatory arthritis

The published report highlighted that QVH is not currently meeting the expected rheumatology services waiting times as recommended by NICE guidance. We are exploring new ways of identifying this patient cohort and freeing up non-urgent capacity to accommodate urgent referrals in a more timely manner.

Sepsis (NCEPOD)

Findings of the study were presented to the trust's joint hospital governance meeting to ensure dissemination. This work was also used to inform the trust's new sepsis policy and pathway and its activity to achieve sepsis-related CQUIN targets. Work is ongoing to ensure that we are able to recognise and treat patients with sepsis effectively.

Gastrointestinal haemorrhage (NCEPOD)

Our processes for transferring gastrointestinal patients to a neighbouring provider after attending QVH were reviewed to ensure they continue to be fit for purpose. The report was also disseminated across the trust for information.

Local clinical audit

The reports of 46 completed local clinical audits were reviewed by QVH in 2015/16. Examples of audit projects undertaken across QVH, their findings and actions taken as a result, include:

NICE clinical guideline 50 - Acutely ill adults in hospital: recognising and responding to deterioration

Overall, the audit, which was carried out in quarter 1 of 2015/16, demonstrated safe care of the acutely ill patients in the sample group. It was evident from the notes that there had been both prompt identification of these deteriorating patients and an appropriate and timely escalation of their care. This is now a rolling audit programme for QVH.

Rehabilitation care for ITU burns patients (incorporating NICE clinical guideline 83)

QVH compliance with the British Burns Association therapy guidelines for the rehabilitation of ITU burns patients (incorporating CG83) during this period of the audit (July-August 2015) was high. The few non-compliant elements of the pathway were due to poor documentation. In response, new burns therapy rehabilitation documentation has been created and introduced for all ITU and ward patients. This ensures that all ITU patients receive the same high standards of rehabilitation. The audit is now part of the local rolling audit programme. In addition, this project has also led to the initiation of two further rolling audits: an audit of rehabilitation care provided for QVH burns inpatients and an audit of multi-speciality compliance with CG83.

Pressure damage - understanding the impact of differences in care

QVH was concerned about an increase in the number of pressure ulcers seen. The audit was developed to explore whether the increase was caused by any differences in the care given to patients with areas of pressure damage of grade 2 or above. The audit found that in some cases care needed to be more individualised and more patient education was required. As a result we have introduced a new assessment tool and patient information leaflet.

Prevention of perioperative hypothermia

Perioperative hypothermia (<36°C) is associated with increased morbidity and mortality (wound infections, transfusion, increased oxygen consumption and shivering). It is therefore imperative that inadvertent hypothermia is prevented in the perioperative period. NICE CG65 recommends that less than 5% of patients undergoing surgery should be less than 36°C at recovery. The audit demonstrated that only 1.6% of patients in the audit experienced hypothermia. It recommended that we continue warming patients intra-operatively using current methods such as heat and moisture exchange filter, warming mattress, and Bair huggers as appropriate. Further work was undertaken to ensure staff are aware of the time interval required for recording temperature when patients are admitted to recovery.

Balance and bone group patient satisfaction

The project found that all of the patients audited felt the course was beneficial, based at the right level for them, and that the questionnaires used were easy to understand. The service will continue the course in this current format and explore the possibility of providing talks to patients on anxiety as part of confidence-building.

Women's health audit

The audit was carried out between February 2014 and January 2015 but the results were presented during 2015/16. The purpose of the women's health audit was to monitor the number of referrals to the women's health physiotherapy service and to explore which conditions are being treated most frequently and how effectively we are treating them. A satisfaction survey is also conducted to see how happy patients are with their treatment and the service they receive. The service sees approximately 100 patients a year and discharges a similar number. The service primarily sees patients for stress incontinence and prolapse. MYMOP (Measure Yourself Medical Outcome Profile) and Quality of Life scores are used as outcome measures and both show that the treatments provided are effective, with 71% of patients reporting a positive change in symptoms by the end of their treatment. Furthermore, in 2015, 100% of patients said they would recommend the service to family and friends.

Compliance with the NPSA alert for conscious sedation with midazolam

The audit found that small quantities of flumazenil (a drug to reverse the effects of anaesthesia, which can also be used to treat an overdose of midazolam) are used across the hospital by appropriately trained staff, in line with the trust's policy. QVH was found to be compliant with the NPSA guidance but it was difficult to ascertain exactly which purpose the flumazenil was used for. Findings were discussed at the medicines management optimisation group and further work will be undertaken to ensure a process is in place to document reasons for use.

Effectiveness and benefit of the multiple sclerosis exercise group

Patients with MS attended an exercise group for six weeks. Therapy outcome measures were used as a standardised tool to measure clinical outcomes. They found a 13.7% improvement in participation with exercise; 16.2% improvement in activity; and 12.7% improvement in wellbeing. There was no change in impairment, suggesting maintenance, which is positive as the condition is chronic and progressive. The combined score of all four outcomes shows a positive improvement of 10.65%. These results demonstrate that the exercise class has a significantly positive clinical impact for these patients.

GP direct access to lumbar spine MRI

This audit to assess whether the pathway was effective found that direct access MRI delivered a better service for patients, as stated by 73% of the GP-referrers in the study. In addition, it was found that lumber MRI cannot be analysed in isolation and must be incorporated into a global assessment of the patient that takes into account patient history and clinical examination.

Pressure garment fabric trial

After trialling a new fabric with increased quality (and in various colours), audit results found that 89% of patients liked having a choice of colour, allowing them to individualise their garment. More significantly, 53% of patients found a difference in the tension of the fabric and 78% of these patients found it to be tighter, resulting in improved clinical outcomes. Clinicians noted that the fabric was true to pattern and shape after 12 weeks. The new quality was an essential improvement to stock in beige and the most popular blue, pink and purple would be offered for resupplies.

Documentation of patient consent and clinical rationale for transfusion

National guidelines recommend that: valid consent for blood transfusion should be obtained from the patient and documented in the clinical record; the reason for transfusion should be clearly documented; and patients should be made aware that they have had a transfusion. The audit found that documented evidence for these recommendations requires improvement. Further work will be undertaken to amend the format of the blood prescription chart, to improve patient information and raise staff awareness.

Commissioning for Quality and Innovation payment framework

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

QVH income in 2015/16 was not conditional on achieving any CQUIN goals because the trust opted for a tariff system that did not include any payment for quality initiatives. However, despite not having this extra funding, QVH decided to drive a number of quality improvement initiatives of its own to ensure the concept of annual quality improvement cycles remained embedded within the organisation and that improvements in patient care would continue to be delivered by clinical staff.

The quality initiatives were:

Identification and treatment of acute kidney injury
An electronic alert for patients who may be developing acute kidney injury (AKI) at QVH was developed and implemented in conjunction with a partner acute hospital trust. A review of AKI cases at QVH was carried out against specific audit measures as recommended by the Kent, Surrey and Sussex Academic Health Science Network. In addition, online teaching is being rolled out to staff, which includes the identification of high risk patients and fluid therapy prescribing.

Identification and treatment of sepsis
A new policy for the early identification and management of patients with sepsis has been introduced, with an accompanying treatment pathway. Work has been undertaken to increase staff awareness of the policy and the importance of sepsis screening and early management.

'Human factors' training
Human factors in healthcare is about applying an understanding of the effects of teamwork, tasks, equipment, the working environment and culture on human behaviour to enhance clinical performance. A programme of human factors training has been made available to all staff across the trust.

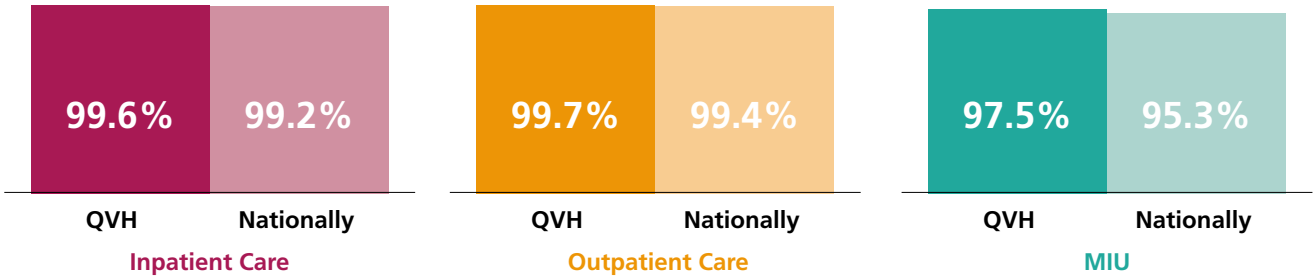
Implementation of the dementia strategy
A trust-wide dementia strategy has been developed with objectives to ensure that people with memory impairments are cared for with dignity and compassion and given any extra support they need. It will be audited during the coming year.

"QVH decided to drive a number of quality improvement initiatives of its own to ensure the concept of annual quality improvement cycles remained embedded within the organisation."

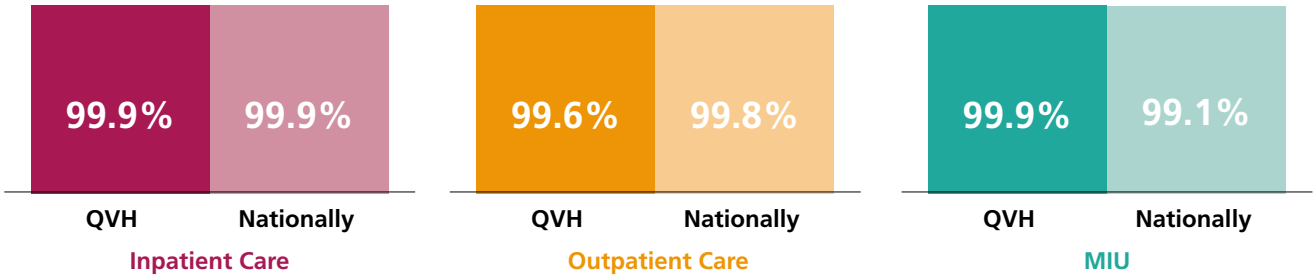
Hospital Episode Statistics

QVH submitted records during 2015/16 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Percentage of records in the published data which include the patient's valid NHS number



Percentage of records which include the patient's valid general medical practice code



Source: The figures are aggregates of the QVH entries taken directly from the SUS data quality dashboard provider view, based on the provisional April 2015 - January 2016 SUS data at the month 10 inclusion date.

Information governance toolkit

Information governance ensures that information held about patients and staff is kept safe and secure. The information governance toolkit is the way in which we demonstrate our compliance with information governance standards. The trust's information governance group oversees the annual submission.

QVH's information governance toolkit overall score for 2015/16 was 77% and graded 'satisfactory'.

During 2015/16, an internal audit of information governance gave the trust an outcome of 'substantial' assurance but also provided a series of recommendations for implementation which will support and improve performance.

All staff and volunteers are mandated to undertake information governance training on an annual basis. During 2015/16 there has been a targeted action plan to increase awareness of responsibilities in relation to safeguarding confidentiality, protecting data and preserving information security.

The trust did not report any significant personal data breaches in 2015/16 and all incidents were graded as causing minor level or no harm to patients. Incidents which do occur are fully investigated and practice is changed where appropriate.

Payment by Results and clinical coding

QVH was subject to the clinical coding audit during the reporting period by an external coding consultancy. Compliance rates reported in the latest published audit for that period for the clinical coding of diagnoses and treatment was:

- Primary diagnoses 95%
- Secondary diagnoses 93.47%
- Primary procedures 94.97%
- Secondary procedures 96.75%.

The results should not be extrapolated further than the actual sample audited.

The following services were reviewed within the sample:

- Children's and adolescent service
- Dentistry and orthodontics
- Ear, nose and throat
- Head and neck cancer services
- Oral and maxillofacial surgery
- Hands
- Ophthalmology
- Plastic surgery
- Sleep medicine
- Breast surgery
- Skin cancer services
- Vascular surgery.

Improving data quality

Data quality refers to the tools and processes that result in the creation of the correct, complete and valid data required to support sound decision-making.

Over the coming year, QVH will take the following actions to improve data quality:

- The data quality improvement group will focus on a range of metrics to enhance data accuracy and completeness through the proactive identification of issues in data quality and improved training penetration to reduce recurrent issues.
- Data warehouse technologies will be installed for information storage and analysis.
- Improved data aggregation and analysis will be implemented to support faster analysis turnaround and the rapid resolution of observed anomalies.
- Data quality reporting and performance management will be enhanced and refined.

Registration with the Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. It ensures that health and social care services provide people with safe, effective, compassionate, high quality care and encourages care services to improve.

QVH is required to register with the CQC and its current status is 'registered without conditions or restrictions'.

The CQC has not taken enforcement action against QVH during 2015/16 and QVH has not participated in any special reviews or investigations by the CQC during this reporting period.

The CQC conducted a routine announced inspection of the trust on 11-12 November 2015. A team of 35 inspectors visited the QVH registered hospital site and conducted a further unannounced spot check on 23 November 2015.

The recommendations and findings from the CQC report have been transferred into our existing continuous improvement action plan. The action plan contains improvements with a primary focus on the critical care findings. Progress against these actions is monitored at the quality and governance committee.

QVH received an overall rating of 'good' across all of the five domains. QVH was rated 'outstanding' for the caring domain and 'good' for the other four domains. The full breakdown of ratings for all five domains assessed by the CQC was:

> "When we inspected QVH, we saw some excellent practice and outstanding care. We saw that staff were incredibly caring and compassionate with patients, and patients praised the care they received."
>
> **Alan Thorne, CQC Head of Hospital Inspections (South East)**

	Minor injuries unit	Specialist burns and plastic services	Critical care	Services for children and young people	Outpatients and diagnostic imaging	Overall
Safe	Good	Good	! Requires improvement	Good	Good	Good
Effective	Good	Good	! Requires improvement	Good	Good	Good
Caring	Good	★ Outstanding	N/A*	★ Outstanding	Good	★ Outstanding
Responsive	Good	Good	Good	Good	Good	Good
Well-led	Good	Good	! Requires improvement	Good	Good	Good
Overall	Good	Good	! Requires improvement	Good	Good	Good

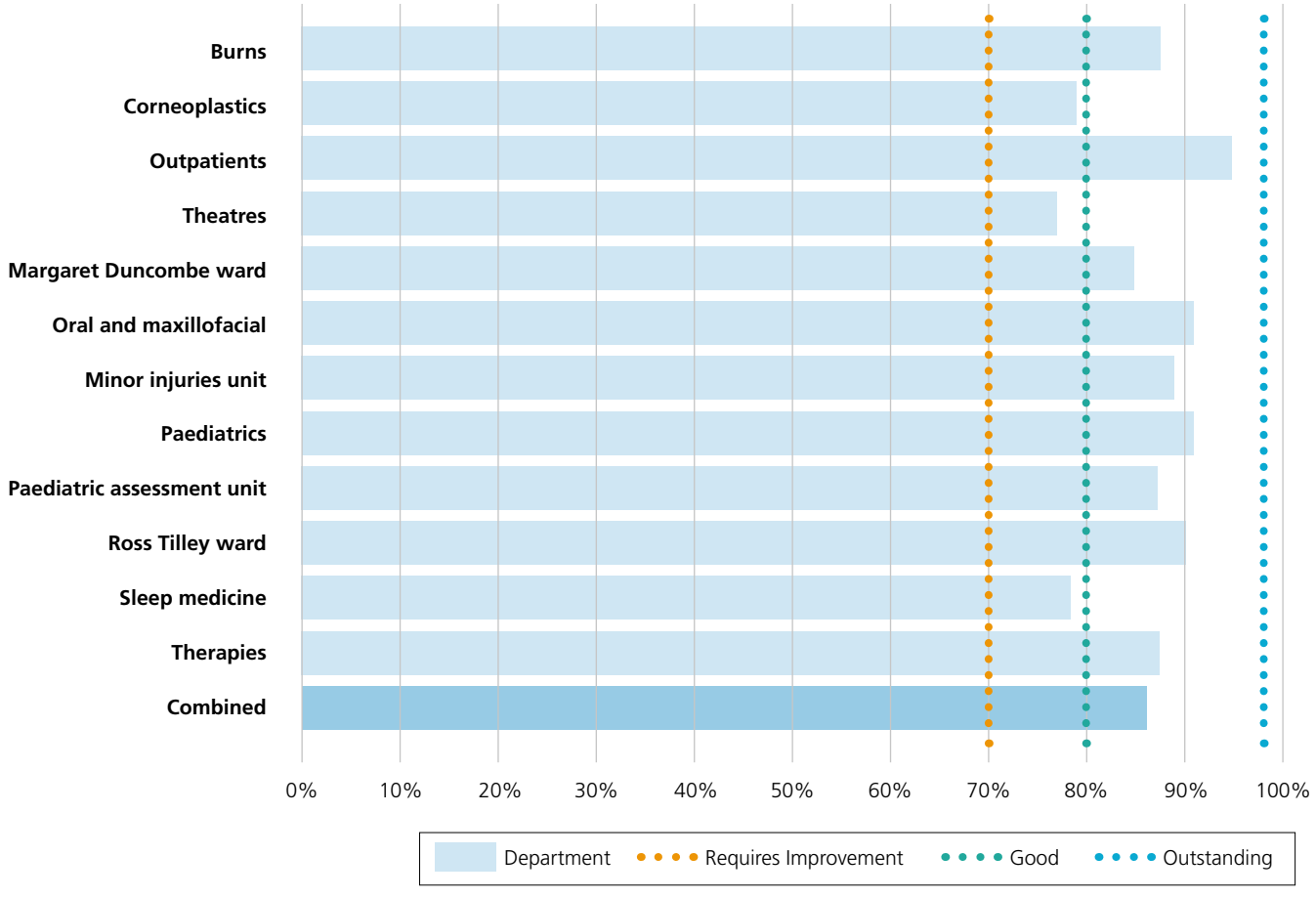
*The CQC inspectors were unable to collect sufficient evidence to rate the caring domain in critical care because only three patients were in the unit at the time of the inspection and two could not be interviewed for clinical reasons.

Compliance in Practice

Compliance in Practice is an improvement initiative undertaken across the trust to measure ongoing compliance with the CQC's essential standards.

To support ongoing compliance against CQC essential standards, QVH re-launched a programme of continuous improvement visits across the site from January 2016. This work builds on the trust's preparations for the CQC inspection and helps to identify weaker areas of practice while ensuring standards of care and treatment are maintained. These visits are undertaken by a variety of staff, public governors and both clinical and non-clinical stakeholders.

Compliance in Practice ratings, quarter 4 2015/16



National core quality indicators

All NHS trusts are required to report their performance against a statutory set of core quality indicators in a predetermined format in their quality reports to enable readers to compare performance across organisations.

For each statutory indicator, our performance is reported together with the national average and the performance of the best and worse performing trusts nationally. Each indicator includes a description of current practice at QVH, preceded by the wording 'we believe this data is as described for the following reasons' which we are required to include.

QVH has also included additional non-mandated quality indicators to provide further detail on the quality of care provided.

Mortality

We believe this data is as described for the following reasons:

- QVH is primarily a surgical hospital which manages complex surgical cases but has only five to ten deaths per year
- QVH has a process in place to review all deaths on site, including those patients who are receiving planned care at the end of their life
- Care provided to patients at the end of their life is assessed to ensure it is consistent with national guidance
- The reason for all deaths is investigated to ensure both internal learning and that relatives are informed of what happened to their loved ones
- Data is collated on all deaths that occur within 30 days after discharge to ensure care at QVH was appropriate
- Deaths are reported monthly to the appropriate service clinical leads for discussion and the development of action points as appropriate
- All deaths are noted and, where necessary, presented and discussed at the bi-monthly joint hospital governance meeting.

In-hospital surgical mortality

2013/14	2014/15	2015/16
0.01%	0.02%	0.03%

Source: QVH information system

QVH continually monitors mortality data by area, speciality and diagnosis on a monthly basis, in particular in the specialities of burns and head and neck oncology, both of which are monitored at regional and national level. We undertake detailed reviews of all deaths to identify any potential areas of learning which can be used to improve patient safety and care quality.

Over the coming three years, QVH will participate in the mortality case record review programme. This programme seeks to develop and implement a standardised way of reviewing the case records of adults who have died in NHS acute hospitals to improve understanding and learning across the NHS about problems in care that may have contributed to a patient's death. We will align internal processes to reflect the findings and learning from this programme as required.

Readmission within 28 days of discharge

We believe this data is as described for the following reasons:

- QVH has a process in place for collating data on patient readmissions to hospital
- Data is collated internally and submitted to the Health and Social Care Information Centre (HSCIC) monthly
- Readmissions are generally to treat some of the complications that may arise from surgery such as wound infections
- We monitor readmissions as a means to ensure our complication rate is acceptable and that we are not discharging patients from hospital too early.

QVH ensures that patient readmissions within 28 days of discharge are discussed at specialty mortality and morbidity meetings and reviewed at the trust's joint hospital governance meeting where appropriate. Information on readmissions is also circulated to all business units and specialties on a monthly basis.

Work is underway to explore whether there are issues around weekend activity and whether operations or discharges over weekends have a higher than expected complication rate. Clinical indicators such as readmissions provide broad indicators of the quality of care and enable us to examine trends over time and identify any areas requiring extra scrutiny.

Emergency readmissions with 28 days

	Discharges		Readmissions		28 days readmission rate	
	14/15	15/16	14/15	15/16	14/15	15/16
Under 16	2,164	2,238	8	21	0.37	0.94
16 +	16,174	17,049	230	175	1.42	1.03
Total	**18,338**	**19,287**	**238**	**196**	**1.30**	**1.02**

Source: QVH information system

National core quality indicators

QVH ensures that patient readmissions within 28 days of discharge are discussed at specialty mortality and morbidity meetings and reviewed at the trust's joint hospital governance meeting where appropriate. Information on readmissions is also circulated to all business units and specialties on a monthly basis.

Work is underway to explore whether there are issues around weekend activity and whether operations or discharges over weekends have a higher than expected complication rate. Clinical indicators such as readmissions provide broad indicators of the quality of care and enable us to examine trends over time and identify any areas requiring extra scrutiny.

Infection control - hand hygiene compliance

We believe this data is as described for the following reasons:

- QVH has a robust process in place for recording compliance with hand hygiene standards
- Hand hygiene is promoted through ongoing education and mandatory training
- Monthly audits are undertaken in all clinical areas to ensure that all staff members across each discipline are complying with standards.

Hand hygiene (washing or alcohol gel use)

Target	2013/14	Target	2014/15
95%	99%	98.4%	99.1%

Source: Internal monthly audit of the five moments of hand hygiene

QVH ensures that hand hygiene remains a priority as it is associated with a reduction in hospital-acquired infections. We are committed to keeping patients safe through continuous vigilance and maintenance of high standards and through robust policies and procedures linked to evidence-based practice and NICE guidance.

Infection control – Clostridium difficile cases

We believe this data is as described for the following reasons:

- QVH has a robust process in place for collating data on C. difficile cases
- Incidents are collated internally and submitted weekly to the clinical commissioning group
- Cases of C. difficile are uploaded to Public Health England
- Results are compared to peers and highest and lowest performers, as well as our own previous performance.

	2012/13	2013/14	2014/15	2015/16
Trust attributed cases	0	1	1	1
Total bed-days	18,790	18,362	15,143	Not published, expected July 2016
Rate per 100,000 bed-days for specimens taken from patients aged 2 years and over (trust attributed cases)	18,338	19,287	238	
National average rate for acute specialist trusts	17.4	14.7	15.1	
Best performing trust	0	0	0	
Worse performing trust	31.2	37.1	62.2	

Source: Health and Social Care Information Centre data

QVH continues to maintain its low infection rate through surveillance supported by robust policies and procedures linked to evidence-based practice and NICE guidance. Infection rates are routinely monitored through the trust's infection prevention and control group and quality and governance committee

Reporting of patient safety incidents

The National Reporting and Learning System (NRLS) is a central database of patient safety incident reports. Since the NRLS was set up in 2003, over four million incident reports have been submitted. It is used to identify hazards, risks and opportunities to continuously improve the safety of patient care.

We believe this data is as described for the following reasons:

- QVH has a process in place for collating data and information on patient safety incidents
- Incidents are collated internally and submitted on a monthly basis to the NRLS.

Patient safety incidents

	2013/14		2014/15		2015/16	
	01/04/13-30/09/13	01/10/13-31/03/14	01/04/14-30/09/14	01/10/14-31/03/15	01/04/15-30/09/15	01/10/15-31/03/16
Total reported patient safety incidents	493	477	476	470		
Incident reporting rate per 1,000 spells	60	54	52	52		
Incidents causing severe harm or death	0	0	1	0		
Percentage of incidents causing severe harm or death	0%	0%	0.2%	0%		
Acute specialist trust benchmarks	**01/04/2013-30/09/2013** (per 100 admissions)	**01/10/2013-31/03/2014** (per 100 admissions)	**01/04/2014-30/09/2014** (per 100 admissions)	**01/10/2014-31/03/2015** (per 100 admissions)		
Lowest incident reporting rate	3.69	4.72	17.63	16.33		
Highest incident reporting rate	27.88	32.88	94.84	108.54	Data expected September 2016	
Specialist trust average total (median)	n=636	n=750	n=745	n=849		
Lowest % incidents causing severe harm	0%	0%	0%	0%		
Lowest % incidents causing death	0%	0%	0%	0%		
Highest % incidents causing severe harm	2.3%	3.6%	3.8%	3.9%		
Highest % incidents causing death	0.8%	0.5%	1.1%	0.9%		
Average % of incidents causing severe harm	0.4%	0.4%	0.4%	0.3%		
Average % of incidents causing death	0.1%	0.1%	0.1%	0.1%		

Source: QVH data from Datix and benchmarking data from NRLS data workbooks on 23/02/2016

QVH encourages all healthcare professionals to report incidents as soon as they occur as we believe that this reflects a positive safety culture. Work has commenced on reducing incident investigation timeframes during 2016/17. This will help to improve the reporting of patient safety incidents to NRLS and NHS England and the identification of key learning aspects for timely dissemination. This is also one of the areas included in our Sign up to Safety pledges which can be viewed on our website, and is one of our local CQUINS for 2016/17.

WHO safe surgery checklist

The World Health Organisation (WHO) safe surgery checklist identifies three phases of an operation, each corresponding to a specific period in the normal flow of work: sign in (before the induction of anaesthesia); time out (before the incision of the skin); and sign out (before the patient leaves the operating room). At each phase, a checklist coordinator must confirm that the surgery team has completed the listed tasks before it continues.

We believe this data is as described for the following reasons:

- WHO checklist compliance is measured monthly for qualitative completion and published in the patient safety metrics
- Compliance is measured quarterly for quantitative completion and reported to the quality and governance committee
- Compliance is scrutinised by audit to identify missing actions or documentation with learning fed back to team meetings
- Results are disseminated throughout the trust for wider learning.

Use of the WHO Safe Surgery checklist

	2013/14	2014/15	2015/16
Sign in	98%	100%	99.58%
Time out	96%	100%	98.05%
Sign out	82%	100%	92.88%
	Target 100%		

Source: Monthly internal audit

Patient safety is paramount at QVH. A whole-team safety briefing with surgical, anaesthetic and nursing staff occurs before the theatre lists begin. This improves communication, teamwork and patient safety in the operating theatre and is embedded in routine practice.

The WHO checklist was a 2014/15 CQUIN which was achieved. The original audit process has continued to ensure that we are able to maintain compliance. We continually review the results and actions for improvement which have included 'human factors' training during 2016.

"Patient safety is paramount at QVH. A whole-team safety briefing with surgical, anaesthetic and nursing staff occurs before the theatre lists begin."

Venous thromboembolism

Patients undergoing surgery can be at risk of venous thromboembolism (VTE) or blood clots. They are a major cause of death in the UK and can be prevented by early assessment and risk identification. The national target is 95% of patients being risk assessed for VTE on admission.

We believe this data is as described for the following reasons:

- QVH has a process in place for collating data on VTE assessment
- Incidences are collated internally and submitted to the Department of Health on a quarterly basis and published by NHS England
- Results are compared to peers, highest and lowest performers and our own previous performance.

VTE assessment rate

	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16
QVH	100%	100%	100%	100%	93.9%	97.5%
National average	96.1%	96.2%	96%	96%	96%	95.9%
National average specialist trusts	**97.4%**	**97.3%**	**97.4%**	**98%**	**98.7%**	**97.7%**
Best performing specialist trust	**99.5%**	**99.1%**	**99.9%**	**100%**	**99.9%**	**100%**
Worst performing specialist trust	**94.6%**	**93.3%**	**94.3%**	**95%**	**95.3%**	**95.1%**

Source: QVH information system

QVH has revised its policies in accordance with NICE clinical guideline 92 and is committed to ensuring that those patients undergoing surgery are risk assessed and the necessary precautions are provided, including compression stockings and low molecular weight heparin.

The NHS 'safety thermometer' is undertaken on a monthly basis in inpatient areas. It provides the trust with a rate of harm-free care provided to patients and includes the assessment of patients for VTE risk on admission and after 24 hours following admission. It also takes into account whether any prescribed prophylaxis medications were administered.

We continuously strive to minimise VTE as one of the most common causes of largely preventable post-operative morbidity and mortality.

Pressure ulcers

We believe this data is as described for the following reasons:

- QVH has a robust process for collating the incidence of pressure ulcers
- A retrospective 'deep dive' and audit have been completed to determine incidence
- The 'Purpose T' tool has been introduced to replace the existing tool to enhance staff awareness and education around pressure damage and teaching sessions have been set up for all areas
- QVH has also trialled and purchased new pressure aiding equipment including hybrid mattresses, seat and head pads and pressure relieving gel pads for long surgical cases.

Development of pressure ulcer grade 2 or above per 1,000 spells

Target	2013/14	2014/15	2015/16
0	0.5 (total = 8)	0.6 (total = 11)	0.9 (total = 17)

QVH endeavours to ensure that the treatment provided to patients does not cause them harm. The figures above reflect hospital-acquired pressure injuries and no pressure injuries sustained were graded as a level 3 or 4.

A pressure ulcer 'deep dive' audit has been undertaken into the care provided at QVH and each pressure ulcer has a full root cause analysis undertaken. Further multidisciplinary training has been undertaken and a new pressure ulcer investigation tool was rolled out in 2015/16.

The majority of pressure ulcers were found to be unavoidable due to the patient's condition, but where learning was identified it has been rolled out in all clinical areas.

Pressure ulcer development in hospital is also measured through data collection for the national 'safety thermometer' and results are monitored internally through the clinical governance group and quality and governance committee.

Same sex accommodation

We believe this data is as described for the following reasons:

- QVH has designated single sex ward areas
- QVH is able to adapt washing and toilet facilities to deliver single sex accommodation
- Any decision to mix in clinically justifiable circumstances is taken by a senior manager.

Failure to deliver single sex accommodation (occasions)

Target	2013/14	2014/15	2015/16
0	0	0	0

QVH is committed to providing every patient with same sex accommodation to ensure that we safeguard their privacy and dignity when they are often at their most vulnerable. We have maintained segregated accommodation during 2015/16 through the use of single rooms and the appropriate planning of patient admissions.

"QVH is committed to providing every patient with same sex accommodation to ensure that we safeguard their privacy and dignity when they are often at their most vulnerable."

NHS friends and family test – patients

We believe this data is as described for the following reasons:

- QVH has a process for collating NHS friends and family test data across all areas of the trust
- Data on inpatient and outpatient services is collated internally and submitted to the Department of Health on a monthly basis and published by NHS England
- Patient responses are collected from cards, text messages and integrated voice messaging
- Response rates and patient responses for 'extremely likely/likely to recommend' and 'unlikely/extremely unlikely to recommend' are compared with our specialist trust peers
- Results are presented to the board of directors on a regular basis.

NHS friends and family test scores (from patients)

	Minor injuries unit		Acute inpatients		Outpatients	
	2014/15	2015/16	2014/15	2015/16	2014/15	2015/16
Percentage extremely likely/likely to recommend	94%	94%	99%	99%	98%	94%
Percentage unlikely/extremely unlikely to recommend	2%	3%	0%	0%	1%	2%
Response rate	27%	25%	43%	51%	7%	18%

Source: QVH information system

QVH continually strives to ensure that patients receive the best care and patient experience while attending our services. Comments received electronically are reviewed on a daily basis so that we are able to respond to potential issues in a timely manner. Friends and family test response rates are amongst the highest in the south of England.

We have a very engaged patient experience manager who is accessible and visible to patients. Our current engagement strategy will continue into 2016/17 and further work is being undertaken to break down responses and comments into weekday and weekend feedback to help inform our continued implementation of seven-day services at QVH. Patient feedback is also used to help us tailor our friends and family test collection methods to help capture the most responses.

We are very proud of our exceptional NHS friends and family test results and will continue to monitor and learn from patient feedback to ensure we sustain the best experience for our patients.

Complaints

We believe this data is as described for the following reasons:

- QVH has a robust complaints management process in place
- The trust has an internal target for responding to all complaints within 30 working days
- All complaints are investigated to ensure appropriate learning
- Complainants who remain dissatisfied are actively supported to go to the Parliamentary and Health Service Ombudsman for assurance that their complaint has been responded to appropriately.

Complaints per 1,000 spells

Target	2013/14	2014/15	2015/16
0	4.7	4.1	2.8

Source: Continuous internal audit

QVH endeavours to respond to all patient and service user complaints in a timely and satisfactory manner to ensure that their issues can be resolved as effectively as possible. We are proud of our year-on-year reduction in formal complaints but continue to use them as an important mechanism to assess the quality of services provided and to understand where improvements can be made.

During 2015/16, only one compliant was referred to the Parliamentary Health Service Ombudsman, and was resolved to the satisfaction of the patient.

NHS friends and family test – staff

We believe this data is as described for the following reasons:

- The data is reviewed by the workforce team and the outcomes are reported to the board of directors
- Data is submitted to the national NHS staff survey on an annual basis for collation and analysis
- Results are compared to peers, highest and lowest performers and our own previous performance
- All staff are encouraged to complete the survey and the response rates are above average.

NHS friends and family test scores (from staff)

	2013/14	2014/15	2015/16
Percentage extremely likely/ likely to recommend	94%	91%	93%
Average (median) for acute specialist trusts	86%	87%	91%
Highest scoring specialist trust	94%	93%	93%
Lowest scoring specialist trust	67%	73%	80%

Source: www.nhsstaffsurveys.com

Over the next 12 months we will continue to promote the NHS staff survey and encourage staff to participate. Any issues or concerns identified will be reported to the board and a suitable action plan developed and implemented. We will use the feedback from the survey to support staff to improve the services we deliver and will share our findings so that we can learn from our mistakes.

Staff experiencing harassment, bullying or abuse

We believe this data is as described for the following reasons:

- QVH reviews the data to identify any trends or spikes in the results
- Differences are reviewed and, where possible, action taken to address issues identified
- All staff are encouraged to complete the survey and the response rates are above average.

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

	Never	1-2	3-5	6-10	10+
QVH	82.4%	13.2%	2.5%	1.1%	0.7%
Average (median) for all trusts	80.4%	13.6%	3.6%	1.1%	1.3%

Source: NHS staff survey

QVH has recently developed a new dignity and respect at work policy and procedure which is used specifically for cases of harassment and bullying. In addition, QVH has a clear policy and process for managing and dealing with concerns (whistleblowing) raised by staff. Over the next 12 months, we will deliver training for all staff on the new policies and will provide managers with further development on how to manage allegations of bullying and harassment.

Equal opportunities for career progression

We believe this data is as described for the following reasons:

- QVH reviews the data to identify the trends or spikes in the results
- Differences are reviewed and, where possible, action taken to address issues identified
- All staff are encouraged to complete the survey and the response rates are above average.

Percentage of staff reporting equal opportunities for career progression and promotion

	Yes	No	Don't know
QVH	61.8%	7.5%	30.7%
Average (median) for all trusts	59.2%	11.0%	29.8%

Source: NHS staff survey

QVH currently delivers high levels of statutory and mandatory training. Over the next 12 months we will focus on delivering training that is aimed at supporting personal development including providing staff with the skills to fully realise their potential and take up progression and promotion opportunities. In addition, we will be encouraging recruiting managers to advertise secondment opportunities that give staff the chance to demonstrate that they have the skills required to undertake more senior job roles.

"Over the next 12 months we will focus on delivering training that is aimed at supporting personal development including providing staff with the skills to fully realise their potential and take up progression and promotion opportunities."

Monitor national priority indicators

Monitor is the independent regulator responsible for authorising, monitoring and regulating NHS foundation trusts.

Monitor uses the following national access and outcomes measures to make an assessment of governance at NHS foundation trusts. Performance against these indicators is used as a trigger to detect any governance issues.

QVH's 2015/16 performance against these indicators was:

			Performance			Quarterly trend			
		National priority indicator	Target	Annual	RAG	Q1	Q2	Q3	Q4
Safety	**Infection control**	Clostridium difficile acquisitions	De-minimis 15	1		0	0	0	1
Experience	**Referral to treatment times**	Percentage of admitted patients treated within 18 weeks April – September	90%	91.42%		92.60%	90.53%		
		Percentage of non- admitted patients treated within 18 weeks April – September	95%	95.37%		96.20%	94.71%		
		Percentage of incomplete pathways less than 18 weeks October – March	92%	94.42%				93.22%	93.31%
	MIU access	Attendees completing treatments and leaving within 4 hours in minor injuries unit	95%	95.05%		99.37%	98.97%	98.82%	99.01%
Effectiveness	**Cancer access – initial appointments**	Urgent cancer referral seen within 2 weeks wait	93%	95.6%		94.80%	94.70%	95.90%	95.4%
	Cancer access – initial treatments	Percentage of cancer patients treated within 62 days of urgent GP referral	85%	82.9%		85.40%	85%	75.90%	86.6%
		Percentage of patients treated within 62 days from screening referral Screening service not offered at QVH, all patients are on a shared pathway with other providers	85%	57.1%		57.10%	66.70%	100%	33.3%
		Percentage of treatment started within 31 days from decision to treat (first treatment)	96%	95.1%		98.50%	98.80%	95.40%	87.5%
		Percentage of treatment started within 31 days from decision to treat (subsequent treatment)	94%	96.4%		97.80%	97.30%	96.10%	93.5%

Source: QVH information system

Monitor national priority indicators

Cancer patients treated within 62 days

The target for all patients to receive their first definitive treatment within 62 days of an urgent GP referral for suspected cancer was met in three of the four quarters of 2015/16. QVH underperformed against the target in quarter 3, primarily due to late referrals from other trusts. We have made a number of improvements, including: regular liaison with off-site management teams to improve processes for joint pathways; discussions with individual trusts when an immediate breach has occurred due to the unavailability of a visiting consultant or any other reason; raising concerns with other trusts and asking them to review systems; and closer liaison with health records managers so that the cancer administration team have full access to all oncology referrals.

18 weeks referral to treatment times

These measures relate to patients who are waiting to be treated. They may have been seen, but are awaiting a first definitive treatment. National and local NHS standards require patients to be admitted for surgery or scheduled (elective) services within 18 weeks of referral by their GP. We are pleased to report that QVH has consistently achieved the open pathway target of 92% every month throughout 2015/16.

Operations cancelled by the hospital for non-clinical reasons

QVH treats over 12,000 surgical cases each year and makes every effort to minimise cancelled operations, as evident in the small numbers in the figures below. However, cancellations are unavoidable on occasions, for example when there are more urgent cases that require a theatre. To minimise cancellations, all patients at risk of cancellation are now escalated to the daily business manager. This ensures that all options are considered and cancellations only occur when all other routes have been explored.

	How data is collected	Target	2013/14	2014/15	2015/16
Cancer - 62 day wait from referral to first definitive treatment	Data collected monthly and reported quarterly; performance includes shared care with other providers	85%	89.3%	87.0%	82.91%
18 weeks - incomplete pathways	Data collected from monthly snapshots	92%	93.8%	93.5%	94.3%
MIU - patients leaving without being seen	Data collected from PAS in the minor injuries unit	5%	1.3%	1.9%	2.4%
Operations cancelled on the day of surgery for non-clinical reasons and not rebooked within 28 days	Data collected from PAS and theatre systems	0	Data not collected for the period	3	4
Urgent operations cancelled for non-clinical reasons for a second or subsequent time	Data collected from PAS and theatre systems	0	Data not collected for the period	3	3

Clinical effectiveness indicators

In 2015/16 QVH's clinical specialities continued to be amongst the most experienced and effective in the world.

Head and neck
Survival after 30 days

126 Major cancer cases

98.4% QVH success rate
98.3% National average

Orthodontics
Improvement in tooth position

14,646 Orthodontic procedures

98% QVH success rate
70% National benchmark

Breasts
Treatment following cancer

259 Breast reconstructions

99.6% QVH success rate
98% National average success rate

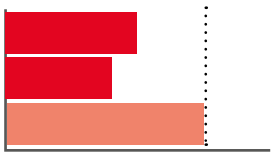
Eyes
Achieved better than 6/12 vision

1,252 Cataract procedures

100% QVH success rate
96% National benchmark

Burns
Average burn wound healing time

1,094 Adult
934 Paediatric



14 days adult
11 days paediatric
‹ 21 days established benchmark

Skin cancer
Melanomas completely removed

248 Melanomas removed

97% QVH complete excision rate
75% National benchmark

Hands
Improvement in function after surgery

1,881 Elective procedures

34 points QVH average
7 points benchmark

Anaesthetics

The anaesthetic department at QVH includes 19 consultant anaesthetists, two associate specialists and eight senior anaesthetic trainees with responsibilities to patients before, during, and after surgery. While much anaesthetist time is spent in operating theatres, anaesthetic doctors work closely with other clinical staff to care for surgical patients throughout the hospital.

Percentage of patients requiring no recovery room intervention following anaesthesia

2013/14	2014/15	2015/16
88%	88%	88%

The anaesthetic recovery room exists to ensure that patients are fit to discharge to the ward following surgery. We monitor all interventions that are made in recovery, including medical review, intravenous analgesia, unexpected discharge to critical care and all complications such as hypothermia or airway difficulties.

Recovery room interventions are a necessary and expected part of perioperative care for a number of patients. A high number of recovery interventions could reflect patients with pre-existing complications, or complications of surgery requiring treatment in the recovery area. They could also reflect variation in anaesthetic care, therefore interventions are recorded for all consultants to look for outlying data requiring further explanation. An intervention-free recovery rate of 88% overall with no outlying data provides assurance of the quality of care. There is no national benchmark for this figure which we collect for internal assurance.

Breast surgery

QVH is the major regional centre for complex, microvascular breast reconstruction either at the same time as a mastectomy for breast cancer (immediate) or after all treatment has been completed (delayed). We are increasingly being asked to carry out reconstruction on the same day as removing both breasts for patients who have a genetic predisposition to breast cancer (BRACA gene). This is likely to increase further due to high profile media attention and improved genetic screening techniques. Our integrated team of consultants and specialist breast care nurses provide a wide range of reconstructive options and flexibility and also undertake reconstructive surgery to correct breast asymmetry, breast reduction and congenital breast shape deformity. We have started breast reconstruction multidisciplinary meetings with one referring hospital and plan to extend this to others.

Breast reconstruction after mastectomy using free tissue transfer – flap survival

The gold standard for breast reconstruction after a mastectomy is a 'free flap' reconstruction using microvascular techniques to take tissue, usually from the abdomen, and use it to form a new breast. This technique has greater patient satisfaction and longevity but can carry greater risks than an implant or pedicled flap reconstruction. It is important that we not only monitor our success in terms of clinical outcomes but also how the patient feels throughout her reconstructive journey. This is called a patient reported outcome (PROM). If the abdomen is insufficient then tissue can be utilised from the inner thigh or the bottom as a free flap for breast reconstruction. QVH consultant Anita Hazari has been instrumental at a national level in the setup, design and implementation of a national free flap registry which will include PROMS.

Breast reconstruction after mastectomy using free tissue transfer - flap survival

Target	Benchmark	2013/14	2014/15	2015/16
100%	95-98% (published literature); 98% (BAPRAS 2009)	98.94%	100%	99.6%

In the coming year, the service will continue to build on the enhanced recovery after surgery (ERAS) pathway and use audit findings to improve and refine this tool to benefit patients. The team hopes to publish its findings in a leading journal on plastic surgery and reconstruction.

In addition, the service is piloting two initiatives going into 2016/17: vascular mapping of vessels for free flaps using magnetic resonance angiography (MRA) and a photo-based post-operative technique which assesses breast volume before and after breast and nipple reconstruction. The service is also starting to carry out breast reconstructions with multiple flaps and combining fat grafting with free flap surgery.

Hand surgery

The hand surgery department accounts for approximately one quarter of elective plastic surgical operations at QVH. It also comprises a majority (approximately 80%) of the trauma workload at the hospital.

The department includes five hand consultants and a comprehensive hand therapy department providing a regional hand surgery service to Kent, Surrey and Sussex. Outreach hand surgery clinics and therapy clinics are held at Medway, Dartford, Faversham, Hastings, Horsham and Brighton. The elective work covers all aspects of hand and wrist surgery including post-traumatic reconstructive surgery, paediatric hand surgery, arthritis, musculoskeletal tumours, Dupuytren's disease and peripheral neurological and vascular pathologies.

The geographical intake for acute trauma comes from most of South East England and South East London and covers all aspects of hand and upper extremity trauma. It is catered for by a 24-hour trauma service with access to two dedicated trauma theatres for inpatient and day-case procedures.

	2013	2014	2015	Jan - Mar 2016
Total elective hand procedures	1422	1893	1881	431
Total trauma cases	2384	3084	2972	680
Total new outpatient appointments	4380	5897	5779	919

The QuickDASH is a standardised questionnaire to measure disability or difficulty in using the hand and the hand therapy department at QVH aims to complete it for all new adult patients. The results are divided into trauma and elective procedures. For trauma patients it is completed by hand therapists at the initial treatment session and at discharge. For elective patients it is completed at the initial treatment session but includes symptoms prior to surgery, and then again on discharge.

A high score reflects greater difficulty in carrying out normal hand functions. A reduction in that score shows the beneficial effect of treatment delivered by the multidisciplinary hand team (primarily physiotherapy, occupational therapy, nurses, surgeons and other medical staff) often over a prolonged treatment episode. A reduction of seven points or more is a material improvement in the ability to use the hand. At QVH we achieve this and more and measuring outcomes enables us to validate and improve the overall quality of the service.

"A reduction of seven points or more in the QuickDASH score is a material improvement in the ability to use the hand. At QVH we achieve this and more and measuring outcomes enables us to validate and improve the overall quality of the service"

QuickDASH

QuickDASH trauma scores before and after treatment

	2014			2015		
	Before	After	Difference	Before	After	Difference
Bone	44.66	5.15	-39.51	41.08	7.4	-33.68
Muscle and tendon	49.27	5.07	-44.2	45.75	5.86	-39.89
Nerve	39.95	3.6	-36.35	46.67	9.82	-36.85
Neural vascular	38.77	6.96	-31.81	36.36	7.85	-28.51
Skin	38.35	5.68	-32.67	36.25	6.99	-29.26
Ligament	36.42	7.95	-28.47	32.77	3.57	-29.2
Multiple trauma	55.75	7.32	-48.43	54.16	6.43	-47.73
Minor trauma	22.69	4.3	-18.39	37.79	7.65	-30.14
Miscellaneous	33.21	6.47	-26.74	32.57	3.78	-28.79
Average	**39.9**	**5.83**	**-34.06**	**40.38**	**6.59**	**-33.78**

QuickDASH elective scores before and after treatment

	2014			2015		
	Before	After	Difference	Before	After	Difference
Tendinopathy	28.28	3.79	-24.49	35.17	13.53	-21.64
Trapeziectomy	44.25	12.32	-31.93	50.18	19.57	-30.61
Fusion (PIP/DIP)	24.97	1.82	-23.15	36.36	19.7	-16.66
Fusion (thumb)	49.99	9.84	-40.15	47.72	9.09	-38.63
CTD and CTS	39.77	4.83	-34.94	37.37	13.87	-23.5
Cubital tunnel	50	19.32	-30.68	40.34	3.41	-36.93
Joint release and tenolysis	37.95	17.5	-20.45	28.28	10.6	-17.68
OA and RA conservative mx	32.33	14.35	-17.98	33.39	23.97	-9.42
Joint replacement (PIP/DIP)	40.05	28.69	-11.36	30.5	11.36	-19.14
Joint replacement (MCP)	48.86	15.91	-32.95	38.82	23.86	-14.96
Xiapex	12.52	4.04	-8.48	14.3	5.22	-9.08
Fasciectomy	23.83	4.96	-18.87	20.4	4.81	-15.59
Dermofasciectomy	23.58	5.24	-18.34	26.29	6.68	-19.61
Major elective (brunelli, etc)	48.56	12.27	-36.29	42.34	17.59	-24.75
Minor elective (trigger, etc)	29.99	6.82	-23.17	28	9.53	-18.47
Average	**35.66**	**10.78**	**-24.88**	**33.96**	**12.85**	**-21.11**

Burns service

The QVH burns service is renowned for providing world-class, multidisciplinary, specialist burns care for adults and children. It provides conservative (non-surgical), surgical and rehabilitative burns care to patients living in a wide geographical area covering Kent, Surrey and parts of South London for all types and sizes of burn. This includes up to high dependency care for children and critical care for adults. Peer support networks and activities are also available for patients.

In addition, QVH provides a burns outreach service, run by a clinical nurse specialist, and a weekly burns clinic for adults and children, led by a consultant and specialist nurse, at the Royal Surrey County Hospital in Brighton. QVH's burns care adviser works closely with referring services and the London South East Burns Network (LSEBN) to ensure a consistent approach to the initial management and referral of patients with a burn injury.

In 2015, the QVH burns service accepted:

- 1,094 adult (>16 years of age) new referrals
  - of which 232 needed inpatient care
  - with 34 requiring intensive care in QVH's critical care unit.
- 934 paediatric (<16 years of age) new referrals
  - of which 68 required inpatient care.

QVH's paediatric ward provides up to high dependency care. Children who have sustained larger burns or require ITU are referred to paediatric burns services within the LSEBN that have the appropriate facilities.

In 2015, five adult burns patients who had sustained major burn injuries died. This equates to an adult burns inpatient mortality rate of 2%. There were no paediatric deaths. All patient deaths are discussed at weekly governance meetings so that any learning points can be identified. If further review is required, the patient's case is discussed at a joint hospital governance meeting. In addition, all burns mortality cases are peer reviewed at the annual LSEBN audit meeting with any 'outlier' cases taken to the national burns mortality meeting. None of the five deaths at QVH in 2015 were considered to be outliers. Sadly, all the patients had sustained injuries which, given their age and / or co-existing medical conditions, it was not possible to survive.

Key burns performance indicators are recorded and analysed through QVH's active participation in the international burns injury database (iBID) programme. This compares QVH's performance with that of all other English burns services in relation to set quality indicators. Overall in 2015, QVH achieved better than the national average for the six valid dashboard indicators for both adult and paediatric burns care.

QVH initiated an innovative programme of continuously monitoring healing times several years ago. There is, as yet, no recognised programme to collect and compare healing times at a national level. Patients who appear likely to exceed QVH targets for healing have their cases reviewed by a consultant and discussed by the MDT with a view to proceeding to surgery to close the wound if the patient agrees.

Burns healing in less than 21 days are less likely to be associated with poor long-term scars. Evidence is now emerging that patients over the age of 65 have similar outcomes even if their healing time is extended to 31 days. However, a shorter burn healing time may reflect better quality of care through dressings, surgery and prevention of infection.

Burns healing times

	Target	2013	2014	2015
Adults 65 years and under wound healing within 21 days	80%	62%	64%	70.40%
Adults >65 years wound healing within 21 days	70%	50%	59%	71.60%
Average time for adult burn wound healing (median)	<21 days	17 days	16 days	14 days
Paediatric (<16 years) wound healing within 21 days	<21 days	88%	88%	86%
Average time for paediatric burn wound healing (median)	<21 days	16 days	10 days	11 days

Head and neck

QVH is the regional tertiary referral centre for major cancer and reconstruction of the head and neck. Our head and neck services are recognised, regionally and nationally, for the specialist expertise offered by our large consultant body which continues to grow, with the addition of a maxillofacial consultant and two ENT consultants in 2015. In particular, QVH is the Kent and Sussex surgical centre for head and neck cancer and is recognised by the Royal College of Surgeons as a training centre for training interface fellows in advanced head and neck oncology surgery.

Total number of major head and neck cancer procedures

2013	2014	2015
65	106	126

The total number of major head and neck patients treated in 2015 was 126, with a 30-day survival rate of 98.4%. This compares with a national benchmark from the DAHNO database of 98.3% for 2014. The 2015 survival rate is pending confirmation by the new national HANA database, which is expected in late 2016.

We endeavour to give the highest quality of patient care and continually strive to improve in line with evidence-based best practice. Multidisciplinary improvements in 2015/16 included trust-wide tracheostomy training in line with NCEPOD recommendations given by surgeons, anaesthetists, physiotherapists, speech and language therapists and specialist nurses. In addition, the increasing number of laryngectomy procedures has allowed us to further extend our training using the same approach.

Enhanced recovery for patients undergoing major head and neck cancer surgery was developed by a multidisciplinary team and began in January 2016. It ensures we involve our patients in the care given by the multidisciplinary and aims to optimise outcomes and reduce lengths of stay.

During 2015/16 we worked towards the implementation of sentinel node biopsy for early oral cancer requiring surgical management, supported by NICE clinical guideline NG14 published in February 2016. We anticipate commencing this service in 2016. Two members of the QVH head and neck consultant body were involved in formulation of these guidelines and are now members of the NICE quality assurance implementation group.

In order to deliver complete head and neck care, including palliative treatments to enhance quality of life, we are well advanced in developing our patient pathways and staff training to enable us to commence electrochemotherapy (ECT) treatment to skin nodules of the head and neck. Currently, patients from Kent, Surrey and Sussex can only access this care in central London and we aim to bring it closer to the patient's home.

We also use audit to enhance best practice and this year introduced a new consent form for major head and neck surgery as the result of an audit. The consent process is complex and we aimed to ensure that major risks and benefits were both discussed in detail and also fully documented for the benefit of patients and the clinicians caring for them. We showed a significant improvement in documentation of consent, with indicator risks comprehensively recorded.

QVH drove a major national audit which found that significant numbers of other head and neck units could benefit from the introduction of a similar consent process and form. This nationwide development is supported by the British Association of Maxillofacial Surgeons.

"We endeavour to give the highest quality of patient care and continually strive to improve in line with evidence-based best practice."

Maxillofacial service - orthognathic treatment

One of the busiest in the UK, the QVH maxillofacial surgery department has four specialist orthognathic consultant surgeons supported by surgical staff, specialist nurses, dieticians, physiotherapists, psychological therapists and speech and language therapists. Our maxillofacial consultant surgeons have a number of interests in the sub-specialisms of their services including orthognathic surgery, trauma, head and neck cancer, salivary glands and surgical dermatology. The QVH service is also hosted across a wide network of acute trusts and community hospitals.

Patient satisfaction with orthognathic treatment

	2013/14	2014/15	2015/16
How do you rate the orthognathic service and care?	83% excellent 17% good	88% excellent 12% good	95% excellent 5% good
How do you rate the quality of surgical care?	N/A	91% excellent 8% good 1% average	94% excellent 6% good
How satisfied are you with facial appearance?	71% very satisfied 28% satisfied 1% neither satisfied nor dissatisfied	68% very satisfied 29% satisfied 3% neither satisfied nor dissatisfied	84% very satisfied 16% satisfied
How satisfied are you with dental appearance?	72% very satisfied 27% satisfied 1% neither satisfied nor dissatisfied	80% very satisfied 20% satisfied	84% very satisfied 16% satisfied

Our satisfaction results for orthognathic surgery are consistently high. For the minority of patients for whom the outcome is not as they would have expected, we review their pathway and endeavour to both address their concerns and ensure that, through systematic review, we continue to improve our service for all.

Orthodontics

QVH's orthodontic clinicians have been collating and investigating their outcomes for almost 20 years, enabling them to consistently validate and improve the quality of care. On the rare occasions when things do not turn out as expected, a root cause analysis is completed to ensure that patient outcomes are continually improved and learning is embedded.

The team use a variety of validated clinical and patient outcome assessments. These include the clinically independent PAR (peer assessment rating), which compares pre- and post-treatment tooth positions, and a patient satisfaction survey to produce a balanced portfolio of treatment assessments that are useful to clinicians and patients and measured against a wider peer group.

The PAR provides an objective measure of the improvement gained by orthodontic treatment. The higher the pre-treatment PAR score, the poorer the bite or occlusion; a fall in the PAR score reflects improvement in the patient's condition. Improvement can be classified into: 'greatly improved', 'improved' and 'worse/no different'. On both scales, QVH scores well. In 2014/15, 98% of our patients were assessed as 'greatly improved' or 'improved'. This is reflected in the table below.

Percentage of patients achieving an outcome in the improved or greatly improved category

	2012/13	2013/14	2014/15*
PAR score	95%	95%	98%

*Data is produced one year in arrears

The care of the small number of patients whose outcomes do not improve is investigated by the team on an annual basis and a root cause analysis undertaken to understand what improvements could be made.

Orthodontics continued

In addition to PAR ratings, patients are asked about their satisfaction with treatment. Every patient who completes orthodontic treatment completes a confidential questionnaire on our outcomes kiosk.

In 2015/16, 181 patients completed the satisfaction questionnaire. The significant majority (86%) were completely satisfied with the result of their treatment and the remaining 12% were fairly satisfied. Furthermore, 98% were happy that their teeth were as straight as they would have hoped.

In addition, 94% of patients were happy with the appearance of their teeth after treatment; 86% reported improved self-confidence; 68% reported an improved ability to keep teeth clean; 62% reported improved ability to chew; and 29% reported improved speech.

A total of 97% of patients felt that they were given sufficient information regarding their proposed treatment; 98% of patients said that they were glad they undertook their course of treatment; and 92% would recommend a similar course of treatment to a friend.

Mandibular advancement splint

Mandibular advancement splint

QVH has one the largest dedicated sleep centres in the UK, responsible for the treatment of sleep-disordered breathing. There is close liaison between the sleep centre and the orthodontics department who receive up to 400 referrals annually for the provision of potential sleep-related treatment. This can include a mandibular advancement splint (MAS), a non-invasive intra-oral appliance that is known to improve the quality of sleep in mild to moderate sleep apnoea.

Over the years, QVH's referrals have increased as patients continue to experience a positive outcome to their apnoeic symptoms. Patients are screened before their referral to the orthodontics department to assess their suitability, with reported success rates from previous audits of 85%.

This year saw the third cycle of the patient satisfaction audit. The audit also aims to identify those patients who are most likely to benefit from a MAS by investigating the clinical parameters that indicate the highest probability of a positive response.

	2014/15	2015/16
Patients wearing the splint at least four nights a week	88%	82%
Patients reporting snoring less or not at all since receiving the splint	50%	79%
Patients suffering from aching teeth and jaws (a common and warned about risk factor of this treatment)	69%	69%
Patients reporting their apnoea has been resolved (usually reported by sleep partners)	80%	83%
Patients reporting their sleep quality is better than before	78%	82%
Patients reporting reduced daytime sleepiness	78%	70%
Patients reporting improved general wellbeing	92%	96%

Overall, the service found an 83% resolution in apnoeic symptoms, which is in line with the published literature.

The questionnaire is currently undergoing some format updates following patient feedback. A digital kiosk has been introduced in the orthodontics department so that patients can complete the MAS questionnaire with ease. A patient information leaflet has also been developed and has received positive feedback.

Skin cancer care and surgery

Our melanoma and skin cancer unit (MASCU) is the tertiary referral centre for all skin cancers across the South East Coast catchment area and is recognised by the Kent and Sussex cancer networks. The multidisciplinary team consists of consultant plastic surgeons, consultant maxillofacial surgeons, consultant ophthalmic surgeons and a consultant dermatologist. QVH also provides specialist dermato-histopathology services for skin cancer.

Complete excision rates in basal cell carcinoma

Target	2013	2014	2015
100%	92.5%	94.1%	96.8%

Basal cell carcinoma (BCC) is the most common cancer in Europe, Australia and the USA. Management usually involves surgical excision, photodynamic therapy (PDT), curettage, immuno-modulators, or a combination. Surgical excision is highly effective with a recurrence rate of 2%. Complete surgical excision is important to reduce recurrence rates. This may not be possible because of the size or position of the tumour or because the incomplete excision will only be evident with histological examination of the excised tissue. In 2015/16, 1,901 BCCs were removed at QVH.

Complete excision rates in malignant melanoma

Target	2013	2014	2015
100% 75% NICE guidance	92.5%	94.1%	96.8%

Melanomas are excised with margins of healthy tissue around them, depending on the type, size and spread of tumour. These margins are set by national and local guidelines and each case is discussed by a multidisciplinary team. Total excision may not be possible because of the health of the patient or the size, position or spread of the tumour, and the team may recommend incomplete excision. In 2015/16, 248 melanomas were removed at QVH.

Corneoplastic and oculoplastic surgery

The corneoplastic unit, including our eye bank, is a high-profile and technologically advanced specialist centre for complex corneal problems and oculoplastics. Specialist cornea services include high-risk corneal transplantation, stem cell transplantation for ocular surface rehabilitation, innovative partial thickness transplants (lamellar grafts) and vision correction surgery.

The team also offers specialist techniques in oculoplastic surgery including Mohs micrographic excision for eyelid tumour management, facial palsy rehabilitation, endoscopic DCR (for tear duct problems) and modern orbital decompression techniques for thyroid eye disease.

Percentage of patients achieving vision better than 6/12 after cataract surgery without other eye disease

Target	Benchmark	2013/14	2014/15	2015/16
100%	96% (UK EPR)	With correction		
		100%	100%	100%
		Unaided		
		90%	92%	94%

In future, the corneoplastic unit will provide an optimised intraocular lens (IOL) power calculation to all patients undergoing cataract surgery. This will enhance visual outcomes and the predictability of refractive outcomes of cataract surgery. Additionally, cataract surgery is customised to fit the specific clinical needs of individual patients. This involves various measures to correct a patient's own refractive error including the use of special custom-made intraocular lens implants. This ultimate goal is to provide patients with an increased quality of vision in a way that also meets their individual needs. The effectiveness of this method will be audited as part of ongoing clinical review.

Sleep disorder centre

The sleep disorder centre was established in 1992 and provides a comprehensive service in sleep medicine for the south east of England. It employs 25 staff, including three consultant physicians and 12 technicians, supported by administrative staff and secretaries. The centre diagnoses and treats all sleep disorders across the south east of England but breathing disturbances during sleep constitute the largest part of referrals.

The centre is one of only a few in the UK with on-site facilities for a full range of treatments for sleep disordered breathing, including continuous positive airway pressure (CPAP), non-invasive ventilation (NIV), orthodontic services for mandibular advancement devices and surgery including bi-maxillary osteotomy as well as a psychotherapy team for CBT treatment of insomnia.

The centre exceeds compliance with 18 week referral to treatment times with an average compliance rate of 99.11% for 2015/16.

The service received over 2,000 new referrals in 2015/16 and performed 1,656 overnight inpatient diagnostic and treatment studies as well as 475 daytime treatment admissions. Consultants and technicians conducted over 8,000 care episodes either as outpatient or telephone clinic appointments with patients.

NHS friends and family tests scores reveal that 97% of patients are extremely likely or likely to recommend the sleep disorder centre for care.

Diagnostic imaging

The diagnostic imaging department provides general radiography, fluoroscopy, ultrasound and cone beam computed tomography services on site. MRI is supplied on site two days each week by a third party provider. We run a diagnostic and therapeutic sialography service once a month. We outsource our CT scanning requirements to neighbouring trusts and private providers.

Our diagnostic imaging services support the outpatient and MIU departments at QVH and also provide important direct access to imaging for the local GP community.

The imaging department is a recognised AQP provider for ultrasound services by the Crawley and Mid Sussex and Horsham CCGs. In November 2015, we partnered with Sussex Community NHS Foundation Trust to provide management and clinical support for their diagnostic imaging departments in the High Weald Lewes and Havens area.

The department prides itself on being patient focused and aims, as far as possible, to provide imaging appointments at a place and at a time most convenient to the patient. Annual surveys show that we run a department that is efficient, effective and empathetic.

Formal internal performance measurement of turnaround times began in 2014. Although there is no agreed national benchmark for this, at QVH we expect to maintain a target of at least 80% of all CT, MRI, Ultrasound and plain film to be reported within 48 hours.

Monthly returns identify waiting time breaches (waits greater than six weeks where the clock has not been stopped for any reason). The increase we have seen this year is the result of increased referrals which are stretching our capacity. This continues to be monitored and plans are being put in place to address this.

	Measurement	2014/15	2015/16
Report turnaround time	Percentage of CT, MRI, ultrasound and plain film reported within 48 hours	52%	85%
Diagnostic waiting times	Number of patients waiting more than 6 weeks for an appointment as reported in DM01 return	8	13
Diagnostic waiting time performance	Percentage of patients referred for CT, MRI or non-obstetric ultrasound seen within 6 weeks of referral	99.56%	99.60%

Therapies

QVH therapy services include physiotherapy, occupational therapy, dietetics and speech and language therapy. Assessment and treatment services are provided for both inpatients and outpatients and therapies are provided within the hospital, in the local community and at other sites across the south east.

We aim to provide a safe, equitable and patient-focused service that delivers value for money and the highest standards of therapy with effective treatment and advice in accordance with evidence-based clinical best practice. Our assessment and treatment interventions aim to:

- Offer the right care in the right place at the right time
- Identify individual patient needs and address these effectively with evidence-based interventions to achieve optimal improvement and avoid chronicity wherever possible
- Provide advice, education and therapy for short and long term management of acute and chronic conditions
- Improve quality of life by empowering patients with self-management programmes, increasing independence and function
- Promote health and wellbeing for all patients and carers
- Avoid unnecessary hospital admissions and facilitate early discharge.

We use a range of validated measures before and after treatment to monitor the effectiveness of our therapy services. These include:

- Patient specific functional score (PSFS) - an outcome measure which assists in identifying activities impaired by illness or injury. Our target is for a change of 3 points or more.
- QuickDASH - measures physical function and symptoms in people with musculoskeletal disorders of the upper limb. A change exceeding 7 points is the most accurate change score for discriminating between improved and stable patients.
- New patient to follow-up ratio (NP:FU) - depending on the service there is often a 'target' ratio which is generally less than six follow-up appointments to every initial appointment on average. Services such as musculoskeletal physiotherapy would be expected to meet a lower ratio of 1:5, whereas services treating long term, progressive conditions will demonstrate higher ratios. Low ratios are not at the expense of clinical outcomes but demonstrate effective and efficient treatment.
- Functional assessment of burns (FAB) review - burns standards state that FAB assessments must be carried out within 24 hours of admission.

We also use a range of measures, including the NHS friends and family test (FFT) and service specific surveys to monitor patient satisfaction.

		Target	2013	2014	2015
Effective (clinical outcomes)	PSFS change (MSK)	≥ 3	4	4.2	4.2
	Quick DASH change (Hands)	>7	N/A	29.5	27.4
Effective (NP:FU)	NP:FU ratio (Physio)	≤ 5	4.2	4.6	4.1
	NP:FU ratio (OT)	≤ 5	3.9	4.9	4.5
	NP:FU ratio (SALT)	≤ 5	4	4.6	3.2
	NP:FU ratio (Dietetics)	≤ 5	3	3.7	4.2
	Average NP:FU ratio	≤ 5	3.8	4.5	4
Patient experience	FFT % likely/very likely to recommend service	>90%	N/A	N/A	95%
	FFT % unlikely/very unlikely to recommend service	<1%	N/A	N/A	0.7%
	Patient satisfaction - MSK (%)	>90%	98%	98%	100%
	Burns standard - FAB review within 24hrs (weekdays) (%)	>90%	N/A	N/A	100%

Statement of director responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare quality accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

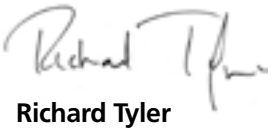
In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2015/16* and supporting guidance;
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2015 - May 2016
  - papers relating to quality reported to the board over the period April 2015 - May 2016
  - feedback from commissioners dated 13 May 2016
  - feedback from governors dated 19 May 2016
  - feedback from Healthwatch West Sussex dated 16 May 2016
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, anticipated July 2016
  - QVH Picker national inpatient survey results, January 2016
  - CQC national inpatient survey results, anticipated June 2016
  - QVH national staff survey results, 22 March 2016
  - the head of internal audit's annual opinion over the trust's control environment dated May 2016
  - official report from the Care Quality Commission dated 26 April 2016
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the quality report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm 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 and is subject to appropriate scrutiny and review; and
- the quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report (both available at www.improvement.nhs.uk).

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,

Beryl Hobson
Chair
23 May 2016



Richard Tyler
Chief Executive
23 May 2016

Statements from third parties

Statement from NHS Crawley and NHS Horsham and Mid Sussex Clinical Commissioning Groups

Crawley and Horsham and Mid Sussex CCGs welcome the opportunity to comment on the 2015/16 quality account for QVH.

The commissioners have worked closely with the trust during the year, gaining assurance of the delivery of safe and effective services. Presentation of a wide range of indicators in relation to quality, safety and performance is presented and discussed at regular meetings between the trust and the CCGs. We acknowledge that this quality account mirrors the information given to the commissioners throughout the year, and the strengthened governance improvements made during the year have been noted.

A review of regulatory inspection is part of the CCGs' quality assurance process and the 'outstanding' rating given for care for the specialist burns and plastic services was a huge achievement, and the overall rating of 'good' reflects the enormous amount of work undertaken by a relatively new leadership team and the staff. We acknowledge the increased emphasis on quality improvement initiatives and risk management and are pleased to note this has been reflected in the three priorities set for 2016/17 built upon patient feedback and other stakeholders.

We acknowledge the openness and honesty with the end of year progress against 2015/16 priorities that not all were met but welcome the pilot for skin patients to enable improvement in the patient experience for the scheduling of elective surgery and roll out across other specialities in 2016/17.

The CCGs note the challenges for the intensive care unit and out of hours cover. This is reflected and clearly evidenced within the document, and the Sign up to Safety pledges have been included in the local CQUINs set for 2016/17.

The commissioners are pleased to endorse this quality account for 2016/17 and we look forward to continuing our excellent relationship so we can all drive forward the improvements and ensure excellent services for the local population.

Statement from Healthwatch West Sussex

Healthwatch West Sussex has worked closer with the trust this year, jointly reviewing performance from the patient and public perspective. For example, we have been involved in the patient engagement group, through independent patient involvement in assessing the quality of the patient environment through the annual PLACE audits, and the quality accounts prioritisation and criteria selection process.

We commend the trust on the overall 'good' rating across the five domains and 'outstanding' rating from the CQC for patient care. We recognise that this achievement has involved a great deal of work for the team. It is good to see that this is being continued in the three priorities identified for 2016/2017: patient safety, clinical effectiveness and patient experience, to continue to build on the work in these areas of 2015/16.

It is good to hear of the shared decision and co-productive ways of working between staff and patients, including telephone clinical reviews. The improvements in catering for patients over the year are excellent. It is good to learn of the new ideas such as the red tray system being implemented.

It was really good to hear about the amount of work in the Duty of Candour area; reporting aligned to the incident reports, patient information leaflet and staff training. This is good progress and reassuring that it is ongoing. That the results for complaints have reduced year-on-year and most are resolved by the trust, is an indicator that robust and appropriate processes are being used and communicated.

The trust and staff are to be commended on the volume of initiatives reported, and standards achieved, regional and national. With regards to the report a glossary would be a useful addition. As cited by Monitor (March 2016, page 4) 'Quality reports help trusts to improve public accountability for the quality of care they provide'. Therefore it is vitally important that the information is clear and consistent, and that each item has a clear plan of action for the coming year.

Healthwatch West Sussex looks forward to continuing to work with the trust next year from the patient and public perspective.

Statements from third parties

Statement from QVH Council of Governors

Whilst governors welcome the ambitious intent to reduce investigation times, they also feel that it is good that QVH recognises that not all investigations (especially the complex cases) will be completed within the targeted timeframes.

The governors note the high standard of quality with regard to the sentinel node biopsy and breast surgery.

It is really good that dementia services and attitudes are praised. One would not expect a purely surgical hospital to do so well in this regard.

It is good that food and catering are improving but the governors recognise that there will always be discontent from some people, especially when they are unwell and are in a postoperative state.

Whilst the governors note the merits of the 'Hello, my name is…' initiative, they nevertheless feel that there is no justifiable reason for staff not introducing themselves personally to patients and visitors.

Governors are delighted to see that QVH is taking pressure ulcers seriously.

Governors note that while QVH is better than the national average for bullying and harassment, they remain concerned that 13% of staff feel bullied and harassed at least once or twice in the last 12 months. Governors expect to see improvement in this area.

Finally, the results, particularly from the CQC inspection, do give thoroughly deserved credit to the staff at QVH. The judgement of 'requires improvement' for critical care is, in part, understandable as it would be impossible to replicate district general hospital or teaching hospital standards on the QVH site. Governors note that the trust recognises this deficiency and makes every effort to improve patient safety and continuity of care.

Independent auditor's report to the council of governors

We have been engaged by the Council of Governors of Queen Victoria Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Queen Victoria Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2016 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following two national priority indicators (the Indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period ("18 week RTT"); and
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

Respective responsibilities of the directors and auditors

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

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2015/16 ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Guidance.

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

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- board minutes and papers for the period April 2015 to May 2016;
- papers relating to quality reported to the board over the period April 2015 to May 2016;
- feedback from commissioners dated 13 May 2016;
- feedback from governors dated 19 May 2016;
- feedback from Healthwatch West Sussex dated 16 May 2016;
- the 2015 national patient survey dated January 2016;
- the 2015 national staff survey dated 22 March 2016;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, in the period April 2015 to May 2016;
- feedback from West Sussex County Council Health and Adult Social Care Select Committee dated April 2016;
- official report for the Care Quality Commission dated 26 April 2016; and
- the 2015/16 Head of Internal Audit's annual opinion over the Trust's control environment.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Queen Victoria Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2016, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Queen Victoria Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

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

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

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

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

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Queen Victoria Hospital NHS Foundation Trust.

Basis for qualified conclusion

As set out in the statement on the Annual Quality Report from the Chief Executive of the Foundation Trust on pages 52 to 53 of the Trust's Annual Governance Statement, the Trust currently has concerns with accuracy of data with regards to the 18 week RTT and 62 day cancer waits indicators.

With regards to the 18 week RTT indicator, we identified control weaknesses in the design of the system and data weaknesses within the first quarter of 2015/16. We identified that there is a weakness in the design of the controls for 18-week RTT, as the data from the satellite site at Medway Hospital is not included as a matter of policy due to unavailability and incompatibility of data provided for activity at this site. Procedures specified for reporting purposes were followed by the clinical team, however, our testing identified that the indicator is not complete. In addition, detailed sample testing of this indicator identified four errors, where there were discrepancies between clock start and stop times recorded on the Patient Administration System ("PAS") and patient referral letters.

As a consequence, we are unable to give limited assurance on the 18 week RTT indicator included in the published Quality Report for the year ended 31 March 2016.

With regards to the 62 day cancer waits indicator, we identified control weaknesses in the design of the system and data weaknesses within the first quarter of 2015/16. In addition, our testing identified seven errors within the data comprising the indicator.

As a consequence, we are unable to give limited assurance on the 62 day cancer waits indicator included in the published Quality Report for the year ended 31 March 2016.

Qualified conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance; and
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance.

KPMG LLP
Chartered Accountants
15 Canada Square
London, E14 5GL

25 May 2016

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Auditor's report and certificate

Independent auditor's report to the council of governors of Queen Victoria Hospital NHS Foundation Trust only

Opinions and conclusions arising from our audit

1 Our opinion on the financial statements is unmodified

We have audited the financial statements of Queen Victoria Hospital NHS Foundation Trust for the year ended 31 March 2016 set out on pages 103 to 128. In our opinion:

- the financial statements give a true and fair view of the state of the group's and the trust's affairs as at 31 March 2016 and of the group's and the trust's income and expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the *NHS Foundation Trust Annual Reporting Manual* 2015/16.

2 Our assessment of risks of material misstatement

In arriving at our audit opinion above on the financial statements the risks of material misstatement that had the greatest effect on our audit were as follows:

We have identified one new risk in this report in comparison with 2014/15 which is the valuation of land and buildings.

Valuation of land and buildings - £35.9 million (2014/15 £32.1 million)

Risk level is increased year on year, this is included as a new significant risk for 2015/16.

Refer to page 34 of the annual report, pages 107 to 113 (accounting policies contained within the trust's annual report) and pages 114 to 128 (financial disclosures contained within the trust's annual report).

The risk: Land and buildings are required to be maintained at up to date estimates of year-end market value in existing use (EUV) for non-specialised property assets in operational use, and, for specialised assets where no market value is readily ascertainable, the depreciated replacement cost of a modern equivalent asset that has the same service potential as the existing property (DRC). There is significant judgment involved in determining the appropriate basis (EUV or DRC) for each asset according to the degree of specialisation, as well as over the assumptions made in arriving at the valuation. In particular the DRC basis requires an assumption as to whether the replacement asset would be situated on the existing site or, if more appropriate, on an alternative site, with a potentially significant effect on the valuation.

In 2015/16 the trust commissioned a full revaluation of land and buildings by an external valuer as at 31 March 2016.

Our response: In this area our audit procedures included:

- Assessing the competence, capability, objectivity and independence of the trust's external valuer and considering the terms of engagement of, and the instructions issued to, the valuer for consistency with the requirements of the *NHS Foundation Trust Annual Reporting Manual*;
- Obtaining the instructions provided to the external valuer and checking that the list of properties to be valued was complete and in line with our knowledge of the trust;
- Critically assessing with the assistance of our own valuation specialists the appropriateness of the valuation bases and assumptions applied to a sample of material assets subject to the revaluation exercise by reference to property records held by the trust on the condition of the assets, the basis of ownership and the basis of their use;
- Undertaking work to understand the basis upon which impairment to land and buildings had been classified by the trust and determining whether the recognition of these losses in the financial statements complied with the requirements of the ARM; and
- Considering the adequacy of the disclosures about the key judgments and degree of estimation involved in arriving at the valuation and the related sensitivities.

NHS revenue recognition – £57.9 million (2014/15, £56.9m)

Risk level is consistent year on year.

Refer to page 34 of the annual report, pages 107 to 113 (accounting policies contained within the trust's annual report) and pages 114 to 128 (financial disclosures contained within the trust's annual report).

The risk: In 2015/16 the trust reported total income of £65.6m (2014/15 £62.9m). £57.9m (2014/15 £56.9m) of this came from contracts with NHS commissioners. This represents 88% of total income (2014/15 90%). The trust participates in the Agreement of Balances (AoB) exercise which is mandated by the Department of Health (the Department), covering the English NHS only, for the purpose of ensuring that intra-NHS balances are eliminated on the consolidation of the Department's resource account. The AoB exercise identifies mismatches between income and expenditure, and receivable and payable balances recognised by the trust and its counter parties at the balance sheet date.

Mismatches can occur for a number of reasons, but the most significant arise where the trust and commissioners are yet to validate the level of estimated accruals for completed healthcare spells which have not yet been invoiced, accruals for non-contracted out-of-area treatments are not recognised by commissioners or potential contract penalties for non-performance are yet to be finalised. Where there is a lack of agreement, mismatches can be classified as formal disputes and referred to NHS England area teams for resolution.

We do not consider NHS income to be at high risk of significant misstatement, or to be subject to a significant level of judgement. However, due to its materiality in the context of the financial statements as a whole, NHS income is considered to be one of the areas which had the greatest effect on our overall audit strategy and allocation of resources in planning and completing our audit.

Our response: In this area our audit procedures included:

- Agreeing the income recorded in the trust's financial statements to the signed material contracts in place with key counter parties, and investigating significant contract variations supported by explanations provided by trust officers.
- Assessing third party confirmations from commissioners and other NHS bodies as part of the 2015/16 Agreement of Balances (AoB) exercise and obtaining explanations for any significant variances.
- Testing a sample of income items to year-end bank statements and third party notifications to support the work we have undertaken on completeness of income balances recorded in the financial statements and confirming that income has been recorded in the correct accounting period.
- Testing a sample of receipts to confirm that income has been recorded in the correct accounting period.

3 Our application of materiality and an overview of the scope of our audit

The materiality for the financial statements was set at £1.25m (2014/15 £1.20m), determined with reference to a benchmark of income from operations, of which it represents 2% (2014/15 2%). We consider income from operations to be more stable than a surplus-related benchmark.

We report to the audit committee any corrected and uncorrected identified misstatements exceeding £62k (2014/15 £61k), in addition to other identified misstatements that warrant reporting on qualitative grounds.

The group has two reporting components (the trust and the charitable fund) and both are subject to audit for group reporting purposes performed by the group audit team at one location in the year for the income and total assets.. The audits performed for group reporting purposes were performed at the trust's headquarters in East Grinstead. The audits cover 100% of group income, with materiality levels ranging from £1.25m to £17k (2014/15 £1.20m to £21k).

4 Our opinion on other matters prescribed by the Code of Audit Practice is unmodified

In our opinion:

- the parts of the remuneration and staff reports to be audited have been properly prepared in accordance with the *NHS Foundation Trust Annual Reporting Manual* 2015/16; and
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

5 We have nothing to report in respect of the matters on which we are required to report by exception

Under ISAs (UK and Ireland) we are required to report to you if, based on the knowledge we acquired during our audit, we have identified other information in the annual report that contains a material inconsistency with either that knowledge or the financial statements, a material misstatement of fact, or that is otherwise misleading.

In particular, we are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our audit and the directors' statement that they consider that the annual report and accounts taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the group's performance, business model and strategy; or
- the audit committee's commentary on page 47 of the annual report does not appropriately address matters communicated by us to the audit committee.

Under the Code of Audit Practice we are required to report to you if in our opinion:

- The annual governance statement does not reflect the disclosure requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2015/16*, is misleading or is not consistent with our knowledge of the group and other information of which we are aware from our audit of the financial statements.
- The trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

In addition we are required to report to you if:

- Any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.
- Any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in respect of the above responsibilities.

Respective responsibilities of the accounting officer and auditor

As described more fully in the statement of accounting officer's responsibilities on page 47 the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the UK Ethical Standards for Auditors.

Scope of an audit of financial statements performed in accordance with ISAs (UK and Ireland)

A description of the scope of an audit of financial statements is provided on our website at www.kpmg.com/uk/auditscopeother2014. This report is made subject to important explanations regarding our responsibilities, as published on that website, which are incorporated into this report as if set out in full and should be read to provide an understanding of the purpose of this report, the work we have undertaken and the basis of our opinions.

Respective responsibilities of the trust and auditor in respect of arrangements for securing economy, efficiency and effectiveness in the use of resources

The trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General (C&AG), as to whether the trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The C&AG determined this criterion as necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

The purpose of our audit work and to whom we owe our responsibilities

This report is made solely to the Council of Governors of the trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the council of governors of the trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the council of governors of the trust, as a body, for our audit work, for this report or for the opinions we have formed.

Certificate of audit completion

We certify that we have completed the audit of the accounts of Queen Victoria Hospital NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Neil Hewitson
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
15 Canada Square
London E14 5GL

23 May 2016

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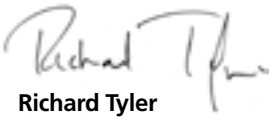
Accounts 2015/16

"QVH formulated plans to address significant cost pressures that emerged during the year and delivered an operational surplus of c£0.8m."

Foreword to the accounts

These accounts for the year ended 31 March 2016 have been prepared by Queen Victoria Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

These accounts are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.



Richard Tyler
Chief Executive
23 May 2016

Statement of comprehensive income

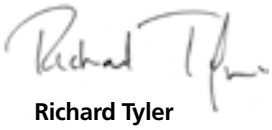
STATEMENT OF COMPREHENSIVE INCOME FOR THE PERIOD ENDED 31 MARCH 2016							
	Notes		**2015/16 Group £000**		**2015/16 Trust £000**	2014/15 Group £000	2014/15 Trust £000
Operating income	3,4		**65,682**		**65,723**	62,866	62,943
Operating expenses	5-7		**(63,144)**		**(63,104)**	(59,613)	(59,547)
Operating surplus/(deficit)			**2,538**		**2,619**	3,253	3,396
Finance costs							
Finance income	10	25		23		21	18
Finance expense – unwinding of discount on provisions	19	(8)		(8)		(8)	(8)
Finance expense – other	20	(240)		(240)		(261)	(261)
PDC dividends payable		(948)		(948)		(884)	(884)
Net finance costs			**(1,171)**		**(1,173)**	(1,132)	(1,135)
SURPLUS/(DEFICIT) FOR THE YEAR			**1,367**		**1,446**	2,121	2,261
Other comprehensive income (See statement of changes in taxpayers' equity on page 105)							
Revaluation gains/(losses) on property, plant and equipment			3,916		**3,916**	-	-
Impairment through revaluation reserve			(229)		**(229)**	-	-
Other reserve movements			-		**-**	-	-
INCOME/(EXPENSE) FOR THE PERIOD			**5,054**		**5,133**	2,121	2,261

The notes on pages 107 to 128 form part of these accounts.

Statement of financial position

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2016					
	Notes	**31 March 2016 Group £000**	**31 March 2016 Trust £000**	31 March 2015 Group £000	31 March 2015 Trust £000
NON-CURRENT ASSETS					
Intangible assets	11	**668**	**668**	975	975
Property, plant and equipment	12	**42,920**	**42,920**	36,730	36,730
Total non-current assets		**43,588**	**43,588**	37,705	37,705
CURRENT ASSETS					
Inventories	14	**439**	**439**	440	440
Trade and other receivables	15	**5,848**	**5,846**	8,351	8,351
Cash and cash equivalents	16	**8,151**	**7,285**	7,446	6,548
Total current assets		**14,438**	**13,570**	16,237	15,339
CURRENT LIABILITIES					
Trade and other payables	17	**(5,776)**	**(5,721)**	(6,333)	(6,327)
Borrowings	21.1	**(778)**	**(778)**	(778)	(778)
Provisions	19	**(140)**	**(140)**	(339)	(339)
Other liabilities	18	**(1,014)**	**(1,014)**	(436)	(436)
Total current liabilities		**(7,708)**	**(7,653)**	(7,886)	(7,880)
NON-CURRENT LIABILITIES					
Provisions	19	**(574)**	**(574)**	(588)	(588)
Long term borrowings	21.1	**(7,378)**	**(7,378)**	(8,156)	(8,156)
Total non-current liabilities		**(7,952)**	**(7,952)**	(8,744)	(8,744)
TOTAL ASSETS EMPLOYED		**42,366**	**41,553**	37,312	36,420
TAXPAYERS' EQUITY (See statement of changes in taxpayers' equity on page 105)					
Public dividend capital		**12,237**	**12,237**	12,237	12,237
Revaluation reserve		**9,143**	**9,143**	5,801	5,801
Income and expenditure reserve		**20,173**	**20,173**	18,382	18,382
Charitable fund reserves		**813**	**-**	892	-
TOTAL TAXPAYERS' EQUITY		**42,366**	**41,553**	37,312	36,420

The accounts on pages 103 to 106 were approved by the board on 19 May 2016 and are signed on the board's behalf by:



Richard Tyler
Chief Executive
23 May 2016

The notes on pages 107 to 128 form part of these accounts.

Statement of changes in taxpayers' equity

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY					
2015/16	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Charitable fund reserve £000	**Total £000**
Group					
Taxpayers' and others' equity at 1 April 2015	**12,237**	**5,801**	**18,382**	**892**	**37,312**
Surplus/(deficit) for the year	-	-	1,329	38	**1,367**
Revaluation of property, plant and equipment	-	3,916	-	-	**3,916**
Impairments	-	(229)	-	-	**(229)**
Public dividend capital received	-	-	-	-	**-**
Other reserves movements	-	(345)	462	(117)	**-**
Taxpayers' and others' equity at 31 March 2016	12,237	9,143	20,173	813	**42,366**
Trust					
Taxpayers' equity at 1 April 2015	12,237	5,801	18,382	-	**36,420**
Surplus/(deficit) for the year	-	-	1,446	-	**1,446**
Revaluation of property, plant and equipment	-	3,916	-	-	**3,916**
Impairments	-	(229)	-	-	**(229)**
Public dividend capital received	-	-	-	-	**-**
Other reserves movements	-	(345)	345	-	**-**
Taxpayers' equity at 31 March 2016	**12,237**	**9,143**	**20,173**	**-**	**41,553**

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY					
2014/15	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Charitable fund reserve £000	**Total £000**
Group					
Taxpayers' equity at 1 April 2014	12,237	6,173	15,749	1,032	**35,191**
Surplus/(deficit) for the year	-	-	2,261	(140)	**2,121**
Revaluation of property, plant and equipment	-	-	-	-	**-**
Impairments	-	-	-	-	**-**
Public dividend capital received	-	-	-	-	**-**
Other reserves movements	-	(372)	372	-	**-**
Taxpayers' equity at 31 March 2015	12,237	5,801	18,382	892	**37,312**
Trust					
Taxpayers' equity at 1 April 2014	12,237	6,173	15,749	-	**34,159**
Surplus/(deficit) for the year	-	-	2,261	-	**2,261**
Revaluation of property, plant and equipment	-	-	-	-	**-**
Impairments	-	-	-	-	**-**
Public dividend capital received	-	-	-	-	**-**
Other reserves movements	-	(372)	372	-	**-**
Taxpayers' equity at 31 March 2015	12,237	5,801	18,382	-	**36,420**

Statement of cash flows

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2016							
	Notes		**2015/16 Group £000**		**2015/16 Trust £000**	2014/15 Group £000	2014/15 Trust £000
Operating surplus			**2,538**		**2,619**	3,253	3,396
Non-cash income and expense							
Depreciation and amortisation	5		**2,573**		**2,573**	2,291	2,291
Impairments	5		**1,383**		**1,383**	-	-
Reversal of impairments	4		**(2,062)**		**(2,062)**	-	-
Loss on disposal of property, plant and equipment	5		**-**		-	5	5
Non-cash donations credited to income	4		**(50)**		**(50)**	(270)	(270)
(Increase)/decrease in inventories	14		**1**		**1**	(25)	(25)
(Increase)/decrease in trade receivables	15		**2,557**		**2,557**	500	500
Increase/(decrease) in trade and other payables	17		**(1,155)**		**(1,155)**	2,102	2,102
Increase/(decrease) in provisions	19		**(221)**		**(221)**	(743)	(743)
Increase/(decrease) in other liabilities	18		**578**		**578**	244	244
NHS charitable funds – net adjustments			**47**		-	-	-
Other movements in operating cash flows			**67**		**67**	-	-
Net cash inflow from operations			**6,256**		**6,290**	7,357	7,500
Cash flows from investing activities							
Interest received	10	**23**		**23**		18	18
Payments to acquire intangible assets	11	**(21)**		**(21)**		(465)	(465)
Payments to acquire property, plant and equipment	12	**(3,528)**		**(3,528)**		(2,208)	(2,208)
NHS Charitable funds – net cash flow from investing activities		**2**		**-**		3	-
Net cash used in investing activities			**(3,524)**		**(3,526)**	(2,652)	(2,655)
Cash flows from financing activities							
Public dividend capital received		**-**		**-**		-	-
Loans from Department of Health	21.1	**-**		**-**		-	-
Loans repaid to the Independent Trust Financing Facility		**(778)**		**(778)**		(778)	(778)
Interest paid	20	**(240)**		**(240)**		(267)	(267)
PDC dividends paid		**(1,009)**		**(1,009)**		(907)	(907)
			(2,027)		**(2,027)**		
Increase in cash			**705**		**737**	2,753	2,893
Cash and cash equivalents at 1 April	16		**7,446**		**6,548**	4,693	3,655
Cash and cash equivalents at 31 March	16		**8,151**		**7,285**	7,446	6,548

The notes on pages 107 to 128 form part of these accounts.

Notes to the financial statements

1 Accounting policies

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2015/16 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

1.1 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.2 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. It is not possible for the NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

1.3 Expenditure on other goods and services

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

1.4 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the cost of the item is at least £5,000; or
- groups of items collectively have a cost of at least £5,000, individually have a cost of more than £250, are functionally interdependent, have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

Valuation

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

To this end, valuations of land, buildings and fixtures are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the balance sheet date. Revaluations are never less than triennial. The latest

valuations were undertaken in 2016 as at the prospective valuation date of 31 March 2016 and were accounted for in the 2015/16 accounts.

Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use.
- Specialised buildings – depreciated replacement cost.

The depreciated replacement cost of specialised buildings is based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

For non-operational properties including surplus land, the valuations are carried out at open market value.

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

Land and buildings are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Equipment is stated in the statement of financial position at its revalued amount, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the balance sheet date. In the intervening periods the trust considers depreciated historic cost to be a suitable estimate of fair value. In the absence of regular markets from which market values can be assessed, revaluations are based on suitable indices such as the Hospital Service Cost Index published by the Department of Health.

Subsequent expenditure

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

Depreciation

Items of property, plant and equipment are depreciated on a straight line basis over their remaining useful economic lives. This is considered to be consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

The remaining economic lives of each element of each building are determined by an independent valuer and each element is depreciated individually. Currently, remaining lives range from three to seventy eight years.

Plant, machinery and medical equipment are generally given lives of five, ten or fifteen years, depending on their nature and the likelihood of technological obsolescence. Information technology equipment is generally given a life of five years.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the trust.

Revaluation and impairment

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income.

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

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

An impairment arising from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

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

Land and buildings were revalued as at 31 March 2016.

The revaluation was carried out by an independent, qualified valuer on the modern equivalent asset basis and the assumption that the property is sold as part of the continuing enterprise in occupation. The valuation was based on the use of an alternative site.

The valuations were carried out on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property.

For specialised buildings where there is no market-based evidence of fair value, the latter is estimated using a depreciated replacement cost approach based on the assumption of the asset's replacement by a modern equivalent asset, in accordance with International Valuation and RICS standards.

For non-operational properties including surplus land, the valuations were carried out at open market value.

Plant and machinery and information technology equipment were last revalued as at 31 March 2008 using suitable indices supplied by the Department of Health. The movement in indices since that time has not been sufficient to affect values materially.

Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.5 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the trust intends to complete the asset and sell or use it;
- the trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset; and
- the trust can measure reliably the expenses attributable to the asset during development.

Software

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

Measurement

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

Subsequently intangible assets are measured at fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the statement of comprehensive income as an item of 'other comprehensive income'.

In the case of software, amortised historic cost is considered to be the fair value.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. In the case of software licenses useful economic life is assumed to be five years.

1.6 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is determined by reference to current prices, using the First In, First Out (FIFO) method.

1.7 Cash and cash equivalents

Cash and cash equivalents include cash in hand, deposits held at call with banks and bank overdrafts. Bank overdrafts are shown within current borrowings in current liabilities on the statement of financial position.

1.8 Trade receivables

Trade receivables are recognised at fair value less provision for impairment. A provision for impairment of trade receivables is established when there is objective evidence that the trust will not be able to collect all amounts due according to the original terms of the receivables. Significant financial difficulties of the debtor, probability that the debtor will enter bankruptcy or financial reorganisation, and default or delinquency in payments (more than 60 days overdue) are considered indicators that the trade receivable is impaired. The amount of the provision is the difference between the asset's carrying amount and the estimated future cash flows. The carrying amount of the asset is reduced through the use of a provision for doubtful debts account, and the amount of the loss is recognised in the income statement within 'operating expenses'. When a trade receivable is uncollectible, it is written off against the provision account. Subsequent recoveries of amounts previously written off are credited against 'operating expenses' in the income statement.

1.9 Trade payables

Trade payables are recognised at fair value. Fair value is deemed to be invoice value less any amounts that the trust does not believe to be due.

1.10 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements, are

recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

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

De-recognition

All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as 'loans and receivables'.

Financial liabilities are classified as 'financial liabilities'.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets at the prices current when the goods or services were delivered.

The trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS debtors, accrued income and 'other debtors'.

Loans and receivables are recognised initially at fair value, net of transaction costs, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Financial liabilities

All financial liabilities are recognised initially at cost, which the trust deems to be fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the statement of financial position date, which are classified as non-current liabilities.

Impairment of financial assets

At the statement of financial position date, the trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cashflows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the statement of comprehensive income and the carrying amount of the asset is reduced through the use of a bad debt provision.

1.11 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to finance costs in the statement of comprehensive income.

Operating leases

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

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Where land is leased for a short term (e.g. ten years) and there is no provision for the transfer of title, the lease is considered to be an operating lease.

The trust as lessor

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.12 Provisions

The NHS foundation trust provides for legal or constructive obligations that are of uncertain timing or amount at the statement of financial position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 19. The trust does not carry any amounts relating to these cases in its own accounts.

Other NHSLA schemes

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

1.13 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.

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

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.14 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that, as PDC is issued under legislation rather than contract, it is not a financial instrument within the meaning of IAS 32.

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

1.15 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.16 Corporation tax

Section 148 of the Finance Act 2004 amended S519A of the Income and Corporation Taxes Act 1988 to provide power to the Treasury to make certain non-core activities of foundation trusts potentially subject to corporation tax. This legislation became effective in the 2005/06 financial year.

In determining whether or not an activity is likely to be taxable a three-stage test may be employed:

- *Is the activity an authorised activity related to the provision of core healthcare?*
  The provision of goods and services for purposes related to the provision of healthcare authorised under Section 14(1) of the Health and Social Care Act 2003 (HSCA) is not treated as a commercial activity and is therefore tax exempt.
- *Is the activity actually or potentially in competition with the private sector?*
  Trading activities undertaken in house which are ancillary to core healthcare activities are not entrepreneurial in nature and not subject to tax. A trading activity that is capable of being in competition with the wider private sector will be subject to tax.
- *Are the annual profits significant?*
  Only significant trading activity is subject to tax. Significant is defined as annual taxable profits of £50,000 per trading activity.

The majority of the trust's activities are related to core healthcare and are not subject to tax. Where trading activities are undertaken that are commercial in nature they are considered insignificant with profits per activity below the £50,000 tax threshold.

No corporation tax was charged to the trust for the financial year ending 31 March 2016.

1.17 Foreign exchange

The functional and presentational currencies of the trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the statement of financial position date) are recognised in income or expense in the period in which they arise.

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

1.18 IASB standard and IFRIC interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2015/16.

The following accounting standards have been issued or amended but have not yet been adopted. NHS bodies cannot adopt new standards unless they have been adopted in the HM Treasury FReM. The HM Treasury FReM generally does not adopt an international standard until it has been endorsed by the European Union for use by listed companies.

i) IFRS 11 - (amendment) - Acquisition of an interest in a joint operation
Not yet adopted by the EU. Expected to be effective from 2016/17.

ii) IAS 16 (amendment) and IAS 38 (amendment) - Depreciation and amortisation
Not yet adopted by the EU. Expected to be effective from 2016/17.

iii) IAS 16 (amendment) and IAS 41 (amendment) - Bearer plants
Not yet adopted by the EU. Expected to be effective from 2016/17.

iv) IAS 27 (amendment) - Equity method in separate financial statements
Not yet adopted by the EU. Expected to be effective from 2016/17.

v) IFRS 10 (amendment) and IAS 28 (amendment) - Sale or contribution of assets
Not yet adopted by the EU. Expected to be effective from 2016/17.

vi) IFRS 10 (amendment) and IAS 28 (amendment) - Investment entities applying the consolidation exception
Not yet adopted by the EU. Expected to be effective from 2016/17.

vii) IAS 1 - (amendment) - Disclosure initiative
Not yet adopted by the EU. Expected to be effective from 2016/17.

viii) IFRS 15 - Revenue from contracts with customers
Not yet adopted by the EU. Expected to be effective from 2017/18.

ix) Annual improvements to IFRS: 2012-15
Not yet adopted by the EU. Expected to be effective from 2017/18.

x) IFRS 9 - Financial instruments
Not yet adopted by the EU. Expected to be effective from 2018/19.

1.19 Critical accounting estimates and assumptions

International accounting standard IAS 1 requires estimates, assumptions and judgements to be continually evaluated and to be based on historical experience and other factors including expectation of future events that are believed to be reasonable under the circumstances. Actual results may differ from these estimates. The purpose of the evaluation is to consider whether there may be a significant risk of causing a material adjustment to the carrying value of assets and liabilities within the next financial year, compared to the carrying value in these accounts.

The following significant assumptions and areas of estimation and judgement have been considered in preparing these financial statements.

Value of land and buildings £35,934,000 (2014/15 £32,118,000) - This is the most significant estimate in the accounts and is based on the professional judgement of the trust's independent valuer with extensive knowledge of the physical estate and market factors. The value does not take into account potential future changes in market value which cannot be predicted with any certainty.

Accruals of income - The major income streams derive from the treatment of patients or from funding provided by government bodies and can be predicted with reasonable accuracy. Provisions are made where there is doubt about the likelihood of the trust actually receiving the income due to it. See Note 15.1.

Income for an inpatient stay can start to be recognised from the day of admission, but cannot be precisely calculated until after the patient is discharged. For patients occupying a bed at the 2015/16 financial year end, the estimated value of partially completed spells is £174,000 (2014/15 £88,000).

Accruals of expenditure - Where goods or services have been received by the trust but have not been invoiced at the end of the financial year, estimates are based on the best information available at the time and where possible on known prices and volumes. See Note 17.

Provisions for early retirements - The trust makes additional pension contributions in respect of a number of staff who have retired early from the service. Provisions have been made for these contributions, based on information from the NHS Pensions Agency. See Note 19.

1.20 Operating segments

An operating segment is a group of assets and operations engaged in providing products or services that are subject to risks and returns that are different to those of other operating segments. Under IFRS 8 an operation is considered to be a separate operating segment if its revenues exceed 10% of total revenues. Operations that contribute less than 10% of total revenue may be aggregated.

The trust derives its income from the provision of healthcare, chiefly in its capacity as a specialist provider of various forms of reconstructive surgery. All services are subject to the same policies, procedures and governance arrangements. They are also subject to to the same regulatory environment and standards set by our external performance managers. Accordingly, the trust operates one segment.

1.21 Consolidation of accounts

The trust is the corporate trustee to the Queen Victoria Hospital NHS Trust Charitable Fund. The trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the trust has the power to govern the financial and operating policies of the charitable fund so as to obtain benefits from its activities for itself, its patients or its staff.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Generally Accepted Accounting Principles (UK GAAP). We have considered the differences between UK GAAP and the *NHS Foundation Trust Annual Reporting Manual* and conclude that there are no material differences in accounting treatment. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the foundation trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

The funds of the charitable fund fall into three categories:

Restricted funds – to be used in accordance with specific restrictions imposed by the donor;

Unrestricted funds - which the trustee is free to use for any purpose in furtherance of the charitable objects of the charitable fund; and

Endowment funds – which, by the stated wish of the donor, the trustee cannot spend as income but which are held as assets from which to generate income.

1.22 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, if significant, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual. Amounts held at the balance sheet date were negligable.

1.23 Pensions

Past and present employees are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. It is not possible for the trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

A more detailed account of the NHS Pension Scheme is given in Note 9.

2. Operating segments

The trust operates a single segment, the provision of healthcare:

	2015/16 Group £000	2015/16 Trust £000	2014/15 Group £000	2014/15 Trust £000
Income	**65,682**	**65,723**	62,866	62,943
Segment surplus	**1,367**	**1,446**	2,121	2,261
Segment net assets	**42,366**	**41,553**	37,312	36,420

3. Income from patient care activities

	2015/16 Group £000	2015/16 Trust £000	2014/15 Group £000	2014/15 Trust £000
Clinical commissioning groups and NHS England	**57,925**	**57,925**	56,940	56,940
Non-NHS:				
Private patients	**175**	**175**	139	139
Injury costs recovery	**253**	**253**	269	269
Other	**891**	**891**	206	206
	59,244	**59,244**	57,554	57,554

Notes:

'Injury costs recovery' is income received through the NHS injury scheme from insurance companies in relation to the treatment of patients who have been involved in road traffic accidents. It is subject to a provision for impairment of receivables of 21.99% to reflect expected rates of collection.

Commissioner requested services

The trust is working with its commissioners to determine the level of commissioner requested services currently provided. Within the 2015/16 financial statements management has taken the view that commissioner requested services are those which provide for the healthcare of NHS patients.

Of the total income reported above, £59,069,000 (2014/15 £57,415,000) was derived from the provision of commissioner requested services.

4. Other operating income

	2015/16 Group £000	2015/16 Trust £000	2014/15 Group £000	2014/15 Trust £000
Education and training	**1,487**	**1,487**	1,574	1,574
Charitable and other contributions	**65**	**182**	409	409
Non-patient care services to other bodies	**1,704**	**1,704**	1,754	1,754
Reversal of impairments	**2,062**	**2,062**	-	-
Other income	**1,120**	**1,044**	1,575	1,652
	6,438	**6,479**	5,312	5,389

5. Operating expenses

	2015/16 Group £000	2015/16 Trust £000	2014/15 Group £000	2014/15 Trust £000
Services from NHS foundation trusts	**129**	**129**	112	112
Purchase of healthcare from non-NHS bodies	**285**	**285**	290	290
Executive directors' costs	**539**	**539**	687	687
Non-executive directors' costs	**111**	**111**	115	115
Staff costs	**40,785**	**40,785**	39,119	39,119
Consultancy	**43**	**43**	124	124
Drugs	**1,382**	**1,382**	1,262	1,262
Supplies and services - clinical (excluding drugs)	**8,382**	**8,382**	8,414	8,414
Supplies and services - general	**591**	**591**	616	616
Establishment	**560**	**560**	492	492
Transport	**465**	**465**	516	516
Premises	**2,480**	**2,480**	2,307	2,307
Provision for impairment of receivables	**408**	**408**	(162)	(162)
Depreciation	**2,312**	**2,312**	2,083	2,083
Amortisation	**261**	**261**	208	208
External audit – statutory audit	**66**	**60**	70	64
– audit-related assurance services	**10**	**10**	10	10
Internal audit services	**54**	**54**	58	58
Clinical negligence	**323**	**323**	336	336
Loss on disposal of plant and equipment	**-**	**-**	5	5
Other	**2,575**	**2,541**	2,951	2,891
	61,761	**61,721**	**59,613**	**59,547**
Impairments of property, plant and equipment	**1,383**	**1,383**	**-**	**-**
	63,144	**63,104**	**59,613**	**59,547**

Note

External audit

The contract between the trust and its auditors provides for the latter's liability to be limited to £1,000,000. External audit fees, exclusive of irrecoverable VAT, were, for statutory audit £54,000 (group) and £49,000 (trust), and for audit related assurance services, £8,000.

Internal audit

Following ARM guidance, 2015/16 separately identifies internal audit expense which was previously reported within the category 'other'.

6. Operating leases

As lessee

Operating leases relate to buildings, medical equipment and vehicles.

Buildings are leased for remaining periods of between two and five years.

All current leases of medical equipment and vehicles are due to expire within one year.

Payments recognised as an expense	2015/16 Group £000	2015/16 Trust £000	2014/15 Group £000	2014/15 Trust £000
Minimum lease payments	**373**	**373**	519	519

6. Operating leases (cont.)

Total future minimum lease payments	2015/16 Group £000	2015/16 Trust £000	2014/15 Group £000	2014/15 Trust £000
Payable:				
Not later than one year	**52**	**52**	51	51
Between one and five years	**647**	**647**	983	983
After five years	**-**	**-**	-	-
Total	**699**	**699**	1,034	1,034

7. Employee benefits and staff numbers

7.1 Employee benefits	2015/16 Group £000	2015/16 Trust £000	2014/15 Group £000	2014/15 Trust £000
Salaries and wages	**32,767**	**32,767**	32,033	32,033
Social security costs	**2,717**	**2,717**	2,652	2,652
Employer contributions to NHS Pension Scheme	**3,912**	**3,912**	3,740	3,740
Agency/contract staff	**2,376**	**2,376**	1,939	1,939
Employee benefits expense	**41,772**	**41,772**	40,364	40,364
Recoveries in respect of seconded staff	**(448)**	**(448)**	(356)	(356)
Non-executive directors' benefits not included above	**111**	**111**	115	115
Total	**41,435**	**41,435**	40,123	40,123

7.2 Average number of people employed	2015/16 Group Number	2015/16 Trust Number	2014/15 Group Number	2014/15 Trust Number
Medical and dental	**140**	**140**	126	126
Administration and estates	**243**	**243**	230	230
Healthcare assistants and other support staff	**126**	**126**	126	126
Nursing, midwifery and health visiting staff	**187**	**187**	175	175
Scientific, therapeutic and technical staff	**159**	**159**	153	153
Bank and agency staff	**59**	**59**	63	63
Total	**914**	**914**	873	873

7.3 Directors' remuneration

Gross salary costs for directors included in note 7.1 for the year ended 31/03/2016 (in their capacity as directors) totalled £650,000 (2014/15 £802,000). There were no advances or guarantees entered into on behalf of directors by the trust.

Employer contributions to the NHS Pension Scheme for executive directors for the year ended 31/03/2016 totalled £70,000 (2014/15 £60,000). The total number of directors to whom benefits are accruing under the NHS defined benefit scheme (the NHS Pension Scheme) was four.

7.4 Staff exit packages for staff leaving in 2015/16

Staff exit packages are payable when the trust terminates the employment of an employee before the normal retirement date or whenever an employee accepts voluntary redundancy in return for these benefits. During the year there were no cases in which contractual payments were made in lieu of notice.

Exit package cost band	**2015/16 Group and trust**		2014/15 Group and trust	
£000	**Number of exit packages**	**Total exit packages by cost band**	Number of exit packages	Total exit packages by cost band
10–25 (payment in lieu of notice)	-	-	2	2
25–50 (compulsory redundancies)	-	-	1	1
Total	-	-	3	3

8. Retirements due to ill-health

During the year there was one early retirement due to ill health at a cost to the NHS pension scheme of £115,000 (2014/15 two at a cost to the NHS pension scheme of £40,000).

9. Pensions costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data at 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

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

The scheme regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the scheme actuary and appropriate employee and employer representatives as deemed appropriate.

c) Scheme provisions

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

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

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

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

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

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

Members can purchase additional service in the NHS Pension Scheme and contribute to money purchase AVCs run by the scheme's approved providers or by other free standing additional voluntary contributions (FSAVC) providers.

10. Finance revenue

	2015/16 Group £000	**2015/16 Trust £000**	2014/15 Group £000	2014/15 Trust £000
Interest revenue from bank accounts	**25**	**23**	21	18

11. Intangible assets - group and trust

Software licences	**2015/16 £000**	2014/15 £000
Gross cost at 1 April	**1,574**	1,109
Additions	**21**	465
Disposals	**(67)**	-
Gross cost at 31 March	**1,528**	1,574
Amortisation at 1 April	**599**	391
Provided during the year	**261**	208
Amortisation at 31 March	**860**	599
Net book value		
Purchased assets at 1 April	**975**	718
Purchased assets at 31 March	**668**	975

12. Property, plant and equipment – group and trust

12.1 Property, plant and equipment at 31 March 2016	Land £000	Buildings £000	Assets under construction £000	Plant and machinery £000	Information technology £000	Total £000
Cost or valuation at 1 April 2015	3,050	30,198	225	12,395	2,175	**48,043**
Additions - purchased	-	136	3,547	344	59	**4,086**
Additions - donated	-	50	-	-	-	**50**
Reclassifications	-	433	(433)	-	-	**-**
Impairments recognised in operating expenses	-	(1,383)	-	-	-	**(1,383)**
Reversal of impairments	1,088	974	-	-	-	**2,062**
Impairments recognised in revaluation reserve	-	(229)	-	-	-	**(229)**
Revaluation	2	3,914	-	-	-	**3,916**
Accumulated depreciation transferred on revaluation	-	(2,299)	-	-	-	**(2,299)**
Disposals	-	-	-	(284)	-	**(284)**
At 31 March 2016	**4,140**	**31,794**	**3,339**	**12,455**	**2,234**	**53,962**
Depreciation at 1 April 2015	-	1,130	-	8,506	1,677	**11,313**
Provided during the year	-	1,169	-	962	181	**2,312**
Accumulated depreciation transferred on revaluation	-	(2,299)	-	-	-	**(2,299)**
Disposals	-	-	-	(284)	-	**(284)**
Depreciation at 31 March 2016	**-**	**-**	**-**	**9,184**	**1,858**	**11,042**
Net book value						
Purchased assets as at 1 April 2015	3,050	26,910	225	3,373	471	**34,029**
Donated assets as at 1 April 2015	-	2,158	-	516	27	**2,701**
Total at 1 April 2015	**3,050**	**29,068**	**225**	**3,889**	**498**	**36,730**
Purchased assets as at 31 March 2016	4,140	29,583	3,339	2,897	356	**40,315**
Donated assets as at 31 March 2016	-	2,211	-	374	20	**2,605**
Total at 31 March 2016	**4,140**	**31,794**	**3,339**	**3,271**	**376**	**42,920**

12.1 Property, plant and equipment (continued)						
2014/15 comparators	Land	Buildings	Assets under construction	Plant and machinery	Information technology	**Total**
	£000	£000	£000	£000	£000	**£000**
Cost or valuation at 1 April 2014	3,050	27,378	2,992	10,351	2,005	**45,776**
Additions – purchased	-	18	480	1,426	146	**2,070**
Additions – donated	-	-	-	270	-	**270**
Reclassifications	-	2,810	(3,240)	406	24	**-**
Disposals	-	(8)	(7)	(58)	-	**(73)**
At 31 March 2015	**3,050**	**30,198**	**225**	**12,395**	**2,175**	**48,043**
Depreciation at 1 April 2014	-	-	-	7,780	1,503	**9,283**
Provided during the year	-	**1,130**	-	779	174	**2,083**
Disposals	-	-	-	(53)	-	**(53)**
Depreciation at 31 March 2015	**-**	**1,130**	**-**	**8,506**	**1,677**	**11,313**
Net book value						
Purchased assets as at 1 April 2014	3,050	25,112	2,992	2,222	468	**33,844**
Donated assets as at 1 April 2014	-	2,266	-	349	34	**2,649**
Total at 1 April 2014	**3,050**	**27,378**	**2,992**	**2,571**	**502**	**36,493**
Purchased assets as at 31 March 2015	3,050	26,910	225	3,373	471	**34,029**
Donated assets as at 31 March 2015	-	2,158	-	516	27	**2,701**
Total at 31 March 2015	**3,050**	**29,068**	**225**	**3,889**	**498**	**36,730**

12.2 Fully depreciated assets

Fully depreciated assets with an aggregate gross carrying value of £8,333,000 are still in use.

12.3 Property, plant and equipment donated during the year

The League of Friends of the Queen Victoria Hospital contributed £50,000 towards the cost of creating lounge facilities in the main ward area.

13. Capital commitments

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

Group and trust	**31 March 2016 £000**	31 March 2015 £000
Property, plant and equipment	**1,123**	273

14. Inventories

Inventories at 31 March	**2015/16 Group £000**	**2015/16 Trust £000**	2014/15 Group £000	2015/15 Trust £000
Drugs	**108**	**108**	95	95
Clinical consumables	**331**	**331**	345	345
Total	**439**	**439**	440	440

15. Trade and other receivables

15.1 Trade and other receivables comprise	31 March 2016 Current Group £000	31 March 2016 Current Trust £000	31 March 2015 Current Group £000	31 March 2015 Current Trust £000
NHS and other related party receivables	**3,547**	**3,547**	6,050	6,050
Other trade receivables	**-**	**-**	-	-
Accrued income	**1,823**	**1,823**	1,645	1,645
Provision for the impairment of receivables	**(1,224)**	**(1,224)**	(816)	(816)
Prepayments	**355**	**355**	349	349
Other receivables	**1,347**	**1,345**	1,123	1,123
Total	**5,848**	**5,846**	8,351	8,351

The majority of trade was with clinical commissioning groups and NHS England, as commissioners for NHS patient care services. As both were funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

15.2 Receivables past their due date but not impaired	31 March 2016 Group £000	31 March 2016 Trust £000	31 March 2015 Group £000	31 March 2015 Trust £000
By up to three months	**637**	**637**	1,075	1,075
By between three and six months	**185**	**185**	132	132
By more than six months	**484**	**484**	332	332
Total	**1,306**	**1,306**	1,539	1,539

15.3 Provision for impairment of NHS receivables	31 March 2016 Group £000	31 March 2016 Trust £000	31 March 2015 Group £000	31 March 2015 Trust £000
Balance at 1 April 2015	**(730)**	**(730)**	(993)	(993)
Amount recovered or written off during the year	**492**	**492**	904	904
Increase in receivables impaired	**(670)**	**(670)**	(641)	(641)
Balance at 31 March 2016	**(908)**	**(908)**	(730)	(730)

The provision represents amounts which are either considerably beyond their due date, known to be in dispute or which the trust considers may be disputed by the debtor body.

15.4 Provision for impairment of non-NHS receivables	31 March 2016 Group £000	31 March 2016 Trust £000	31 March 2015 Group £000	31 March 2015 Trust £000
Balance at 1 April 2015	**(86)**	**(86)**	(28)	(28)
Amount recovered or written off during the year	**111**	**111**	12	12
Increase in receivables impaired	**(341)**	**(341)**	(70)	(70)
Balance at 31 March 2016	**(316)**	**(316)**	(86)	(86)

16. Cash and cash equivalents

	31 March 2016 Group £000	31 March 2016 Trust £000	31 March 2015 Group £000	31 March 2015 Trust £000
Balance at 1 April 2015	**7,446**	**6,548**	4,693	3,655
Net change in year	**705**	**737**	2,753	2,893
Balance at 31 March 2016	**8,151**	**7,285**	7,446	6,548
Comprising:				
Cash with the Government Banking Service (GBS)	**7,265**	**7,265**	6,542	6,542
Commercial banks and cash in hand	**886**	**20**	904	6
Cash and cash equivalents as in statement of cash flows	**8,151**	**7,285**	7,446	6,548

17. Trade and other payables

	31 March 2016 Group £000	31 March 2016 Trust £000	31 March 2015 Group £000	31 March 2015 Trust £000
NHS payables	**1,380**	**1,380**	1,096	1,096
Trade payables – capital	**638**	**638**	80	80
Other payables – revenue	**1,061**	**1,061**	1,852	1,852
Accruals	**1,858**	**1,803**	2,512	2,506
	4,937	**4,882**	5,540	5,534
Tax and social security costs	**839**	**839**	793	793
Total	**5,776**	**5,721**	6,333	6,327

NHS payables include £562,000 outstanding pensions contributions at 31 March 2016 (31 March 2015 £523,000).

18. Deferred income

Current	31 March 2016 Group £000	31 March 2016 Trust £000	31 March 2015 Group £000	31 March 2015 Trust £000
Total	**1,014**	**1,014**	436	436

19. Provisions

Current	31 March 2016 Group £000	31 March 2016 Trust £000	31 March 2015 Group £000	31 March 2015 Trust £000
Pensions relating to staff	**27**	**27**	27	27
Legal claims	**6**	**6**	1	1
Contract provision	**107**	**107**	311	311
Total	**140**	**140**	339	339

Non-current	31 March 2016 Group £000	31 March 2016 Trust £000	31 March 2015 Group £000	31 March 2015 Trust £000
Pensions relating to staff	**574**	**574**	588	588

Movements in-year – group and trust	Pensions relating to staff £000	Legal claims £000	Contract provision £000	Total £000
At 1 April 2015	**615**	**1**	**311**	**927**
Change in discount rate	**(5)**	**-**	**-**	**(5)**
Arising during the year	**10**	**6**	**16**	**32**
Used during the year	**(27)**	**(1)**	**-**	**(28)**
Reversed unused	**-**	**-**	**(220)**	**(220)**
Unwinding of discount	**8**	**-**	**-**	**8**
At 31 March 2016	**601**	**6**	**107**	**714**

Expected timing of cash flows:				
Within one year	**27**	**6**	**107**	**140**
Between one and five years	**99**	**-**	**-**	**99**
After five years	**475**	**-**	**-**	**475**
	601	**6**	**107**	**714**

The provision for pensions relating to staff consists of £553,000 in respect of injury benefit (31 March 2015 £563,000) and £48,000 in respect of early retirements (31 March 2015 £52,000). The amounts represent the discounted future value of annual payments made to the NHS Pensions Agency calculated on an actuarial basis.

'Legal Claims' are claims relating to third party and employer's liabilities. Where the case falls within the remit of the risk pooling schemes run by the NHS Litigation Authority (NHSLA), the trust's liablility is limited to £3,000 or £10,000 depending on the nature of the case. The remainder is borne by the scheme. The provision is shown net of any reimbursement due from the NHSLA.

£2,039,000 was included in the provisions of the NHS Litigation Authority at 31 March 2016 in respect of clinical negligence liabilities of the trust (31 March 2015 £2,528,000).

20. Finance expense

Interest expense	31 March 2016 Group and trust £000	31 March 2015 Group and trust £000
Loans from the Foundation Trust Financing Facility (Department of Health)	**240**	261

21. Financial instruments

Accounting standards IAS 32, 39 and IFRS 7 require disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities.

Financial instruments are recognised and measured in accordance with the accounting policy described under Note 1.10.

21.1 Financial assets and liabilities by category

All financial assets and liabilities are denominated in sterling.

Financial assets	**31 March 2016** **Group £000**	**31 March 2016** **Trust £000**	31 March 2015 Group £000	31 March 2015 Trust £000
Loans and receivables:				
NHS and other related party receivables	**2,323**	**2,323**	6,050	6,050
Accrued income	**1,823**	**1,823**	1,645	1,645
Other receivables	**1,153**	**1,151**	307	307
Cash at bank and in hand	**8,151**	**7,285**	7,446	6,548
Total	**13,450**	**12,582**	15,448	14,550

The above balances have been included in the accounts at amortised cost as 'loans and receivables', with no financial assets being classified as 'assets at fair value through the statement of comprehensive income', 'assets held to maturity' nor 'assets held for resale'.

Financial liabilities	**31 March 2016** **Group £000**	**31 March 2016** **Trust £000**	31 March 2015 Group £000	31 March 2015 Trust £000
Carrying value:				
Borrowings	**8,156**	**8,156**	8,934	8,934
Trade and other payables	**3,047**	**2,992**	2,935	2,935
Accrued expenditure	**1,803**	**1,803**	2,512	2,506
Total	**13,006**	**12,951**	14,381	14,375

'Borrowings' represents a loan from the Foundation Trust Financing Facility provided by the Department of Health.

All financial liablities are classified as 'other financial liabilities', with no financial liabilities being classified as 'liabilities at fair value through the statement of comprehensive income'.

Other tax and social security cost amounts of £839,000 (2014/15 £793,000) and deferred income of £1,014,000 (2015/16 £436,000) are not classed as financial instruments and have therefore been excluded from the above analysis.

21.2 Maturity of financial assets

All of the trust's financial assets mature within one year.

21.3 Maturity of financial liabilities

All of the trust's financial liabilities fall due within one year with the exception of the £7,378,000 portion of the borrowings that falls due after more than one year.

21.4 Derivative financial instruments

In accordance with IAS 39, the trust has reviewed its contracts for embedded derivatives that are required to be separately accounted for if they do not meet the requirements set out in the standard. Accordingly the trust has no embedded derivatives that require recognition in the financial statements.

21.5 Financial risk management

Due to the service provider relationship that the trust has with clinical commissioning groups and NHS England and the way those bodies are financed, the trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS trust in undertaking its activities.

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

Currency risk

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

Credit risk

Because the majority of the trust's income comes from contracts with other public sector bodies, the trust has low exposure to credit risk. The maximum exposures as at 31 March 2016 are in receivables from customers, as disclosed in note 15.

Liquidity risk

The trust's operating costs are incurred under contracts with clinical commissioning groups, which are financed from resources voted annually by Parliament. The trust is not, therefore, exposed to significant liquidity risks.

22. Related party transactions

No board members or members of the key management staff or parties related to them undertook any transactions with Queen Victoria Hospital NHS Foundation Trust during 2015/16 (2014/15 none).

McIndoe Surgical Centre Ltd was previously recognised as a related party. In 2015/16 this company was taken over by a charity and is no longer treated as a related party.

Other public sector bodies included within the Whole of Government Accounts are also deemed to be related parties. The trust has financial transactions with many such bodies.

Whole of Government Accounts bodies	**2015/16**		2014/15	
Bodies with whom either income or expenditure exceeded £150,000 during the year:	**Income £000**	**Expenditure £000**	Income £000	Expenditure £000
Income and expenditure				
Brighton and Sussex University Hospitals NHS Trust	89	980	76	920
Guy's and St Thomas' NHS Foundation Trust	154	10	103	17
Maidstone and Tunbridge Wells NHS Trust	223	82	258	68
Dartford and Gravesham NHS Trust	7	721	2	718
Medway NHS Foundation Trust	29	911	5	881
East Sussex Hospitals NHS Trust	24	754	38	875
NHS Litigation Authority	-	323	-	336
Health Education England	1,395	-	1,548	1
NHS England	22,337	-	21,055	7
NHS Ashford CCG	526	-	561	-
NHS Bexley CCG	476	-	554	-
NHS Brighton and Hove CCG	1,060	-	1,030	-
NHS Bromley CCG	559	-	627	-
NHS Canterbury and Coastal CCG	749	-	697	-
NHS Coastal West Sussex CCG	2,140	-	1,987	-
NHS Crawley CCG	1,555	-	1,583	-
NHS Croydon CCG	274	-	336	-
NHS Dartford Gravesham and Swanley CCG	2,374	-	2,423	-
NHS East Surrey CCG	2,723	-	2,786	-
NHS Eastbourne Hailsham and Seaford CCG	1,237	-	1,067	-
NHS Guildford and Waverley CCG	593	-	431	-
NHS Hastings and Rother CCG	1,627	-	1,695	-
NHS High Weald Lewes Havens CCG	3,295	107	3,376	-
NHS Horsham and Mid Sussex CCG	5,318	-	5,669	-
NHS Medway CCG	2,331	-	2,523	-
NHS North West Surrey CCG	151	-	102	
NHS South Kent Coast CCG	702	-	772	-
NHS Surrey Downs CCG	816	-	797	-
NHS Swale CCG	1,122	-	983	-
NHS Thanet CCG	375	-	482	-
NHS West Kent CCG	5,310	-	5,111	-
	59,571	**3,888**	58,677	3,823

	2015/16		2015/16	
	Receivables £000	**Payables £000**	Receivables £000	Payables £000
Receivables and payables				
Brighton and Sussex University Hospitals NHS Trust	466	189	168	185
Guy's and St Thomas' NHS Foundation Trust	93	4	76	6
Maidstone and Tunbridge Wells NHS Trust	183	23	66	36
Dartford and Gravesham NHS Trust	7	60	-	60
Medway NHS Foundation Trust	58	253	32	204
East Sussex Hospitals NHS Trust	-	133	12	109
NHS Litigation Authority	-	-	-	-
Health Education England	115	-	25	-
NHS England	1,683	23	3,398	-
NHS Ashford CCG	54	-	173	-
NHS Bexley CCG	-	50	-	40
NHS Brighton and Hove CCG	-	66	-	161
NHS Bromley CCG	-	41	-	70
NHS Canterbury and Coastal CCG	5	6	62	-
NHS Coastal West Sussex CCG	126	-	102	-
NHS Crawley CCG	66	-	77	-
NHS Croydon CCG	-	61	-	79
NHS Dartford Gravesham and Swanley CCG	-	122	20	-
NHS East Surrey CCG	36	-	161	-
NHS Eastbourne Hailsham and Seaford CCG	217	-	273	-
NHS Guildford and Waverley CCG	100	-	-	15
NHS Hastings and Rother CCG	-	67	210	-
NHS High Weald Lewes Havens CCG	212	70	292	-
NHS Horsham and Mid Sussex CCG	345	-	815	-
NHS Medway CCG	-	78	268	-
NHS North West Surrey CCG	39	-	39	-
NHS South Kent Coast CCG	25	-	54	-
NHS Surrey Downs CCG	5	-	69	-
NHS Swale CCG	69	-	3	-
NHS Thanet CCG	-	14	-	56
NHS West Kent CCG	294	-	636	-
	4,198	**1,260**	7,031	1,021

23. Intra-government and other balances

Receivables: amounts falling due within one year	31 March 2016 Group £000	31 March 2016 Trust £000	31 March 2015 Group £000	31 March 2015 Trust £000
Balances with NHS bodies	**5,186**	**5,186**	7,436	7,436
Balances with other government bodies	**390**	**390**	255	255
Balances with bodies external to government	**1,496**	**1,494**	1,476	1,476
Provision for the impairment of receivables	**(1,224)**	**(1,224)**	(816)	(816)
	5,848	**5,846**	8,351	8,351

Payables: amounts falling due within one year	31 March 2016 Group £000	31 March 2016 Trust £000	31 March 2015 Group £000	31 March 2015 Trust £000
Balances with NHS bodies	**1,371**	**1,371**	788	788
Balances with other government bodies	**1,473**	**1,473**	1,412	1,412
Balances with bodies external to government	**2,932**	**2,877**	4,133	4,127
	5,776	**5,721**	6,333	6,327

24. Losses and special payments

Losses and special payments are calculated on an accruals basis.

There were 42 cases of losses and special payments totalling £4,000 approved during 2015/16 (four cases totalling £31,000 in 2014/15).

All cases are reported on an accruals basis, but do not include provisions for future losses.

There were no fraud cases within these losses.

25. Third party assets

The trust holds minimal levels of third party assets, usually related to patients' monies.

5

Appendices

7.1 Board of directors register

Name, title and appointment	Meeting attendance and role 2015/16						
	Board of directors	**Council of governors**	**Audit committee**	**QVH Charity committee**	**Nomination and remuneration committee**	**Quality and governance committee**	**Finance and performance committee**
Ginny Colwell* Non-Executive Director 1 October 2013 to 28 February 2016	8 of 10** Member	3 of 4 Attendee	4 of 4 Member	–	2 of 4 Member	6 of 8 Chair	–
Independent Clinical Adviser 3 March 2016 to 21 April 2016	1 of 1 Adviser	Not applicable	1 of 1 Adviser	–	1 of 1 Adviser	1 of 1 Adviser	–
Stephen Fenlon Medical Director 1 April 2013 to present	11 of 11** Member	3 of 4 Attendee	–	4 of 4 Member	–	9 of 9 Member	–
Beryl Hobson Chair 1 April 2015 to 31 March 2018	10 of 11** Chair	4 of 4	1 of 1 Member***	4 of 4 Member	3 of 3 Member 2 of 2 Chair	–	8 of 10 Member
Ian Playford Non-Executive Director 10 April 2015 to 31 March 2018	10 of 11** Member	2 of 3 Attendee	–	–	4 of 5 Member	–	8 of 10 Member
Lester Porter Non-Executive Director and Senior Independent Director 1 September 2011 to 31 August 2017	11 of 11** Member	3 of 4 Attendee	2 of 2 Member 3 of 3 Chair	4 of 4 Chair	3 of 3 Chair 2 of 2 Member	6 of 8 Member 1 of 1 Chair****	–
Clare Stafford Director of Finance 1 June 2015 to present	6 of 9** Member	3 of 3 Attendee	4 of 4 Attendee	4 of 4 Member	–	4 of 8 Member	8 of 10 Member
Jo Thomas Director of Nursing 1 February 2015 to present	11 of 11** Member	3 of 4 Attendee	4 of 5 Attendee	–	–	8 of 9 Member	7 of 10 Member
Dominic Tkaczyk Interim Director of Finance 17 December 2014 to 31 May 2015	2 of 2 Member	0 of 1 Member	2 of 2 Attendee	Not applicable	–	1 of 1 Member	Not applicable
John Thornton Non-Executive Director 1 October 2013 to 30 September 2016	9 of 11** Member	2 of 4 Attendee	3 of 5 Member	–	4 of 5 Member	–	10 of 10 Chair
Richard Tyler Chief Executive 1 July 2013 to present	11 of 11** Member	4 of 4 Attendee	4 of 5 Ex-officio	–	4 of 4 Member	4 of 9 Member	8 of 10 Member

* In February 2016 QVH discovered that Ginny Colwell was not eligible to be a member of Queen Victoria Hospital NHS Foundation Trust because her home address was not, at that time, within one of the electoral wards defined in Annex 1 of the trust's constitution. Once the defect in Ginny Colwell's appointment became apparent, legal advice was sought and she was removed from the register of members and the register of directors so as not to leave the trust in breach of its constitution and licence. At its meeting held in public on 3 March 2016 the board of directors appointed Ginny Colwell as an independent clinical adviser while the board and council of governors considered potential changes to the constitution that would incorporate her electoral ward (among others) into the public constituency, allow her to join the trust as a member and to be considered for appointment as a non-executive director.

** Total number of formal meeting sessions held in public and in private.

*** Further to the removal of Ginny Colwell from the register of members and the register of directors, Beryl Hobson joined the audit committee temporarily in place of Ginny Colwell.

**** Further to the removal of Ginny Colwell from the register of members and the register of directors Lester Porter acted as chair of the quality and governance committee.

7.2 Council of governors register

Name	Constituency	Status of current term	Start of term	End of term	Meeting attendance
Beesley, Brian[1]	Public	Re-elected 2nd term	01/07/2014	30/06/2017	4 of 4
Belsey, John[2]	Public	Elected 1st term	01/07/2014	30/06/2017	4 of 4
Bennett, Liz	Stakeholder[3]	Appointed	01/07/2013	30/06/2017	3 of 4
Bowers, John	Public	Elected 1st term	01/07/2013	30/06/2016	3 of 4
Chimonas, Milton	Public	Elected 1st term	01/07/2013	30/06/2016	4 of 4
Cunnington, Jenny	Public	Re-elected 2nd term	01/07/2014	30/06/2017	3 of 4
Dabell, John	Public	Re-elected 2nd term	01/07/2014	30/06/2017	2 of 4
Dudgeon, Robert	Public	Elected 1st term	01/07/2013	30/06/2016	4 of 4
Glynn, Angela	Public	Elected 1st term	01/07/2014	30/06/2017	2 of 4
Goode, Brian[4]	Public	Re-elected 2nd term	01/07/2013	30/06/2016	2 of 4
Halloway, Chris	Public	Elected 1st term	01/07/2015	30/06/2018	4 of 4
Harold, John[5]	Public	Elected 1st term	01/07/2012	30/06/2015	3 of 4
Higgins, Anne	Public	Re-elected 2nd term	01/07/2014	30/06/2017	4 of 4
Martin, Tony[6]	Public	Elected 1st term	01/07/2014	30/06/2017	2 of 4
McMillan, Moira	Public	Re-elected 2nd term	01/07/2013	30/06/2016	3 of 4
Mockford, Julie	Staff	Elected 1st term	01/07/2014	30/06/2017	4 of 4
Orman, Christopher[7]	Public	Re-elected 2nd term	01/07/2014	30/06/2017	4 of 4
Rashid, Mansoor	Staff	Elected 1st term	01/07/2014	30/06/2017	2 of 4
Robertson, Andrew	Stakeholder[8]	Appointed	01/07/2013	Ongoing	3 of 4
Roche, Glynn[9]	Public	Elected 1st term	01/07/2014	30/06/2017	4 of 4
Rudin, Rodabe[10]	Public	Elected 1st term	01/07/2015	30/06/2018	1 of 1
Santi, Gillian	Public	Re-elected 2nd term	01/07/2014	30/06/2017	4 of 4
Shaw, Michael	Public	Re-elected 2nd term	01/07/2014	30/06/2017	4 of 4
Smith, Shona	Staff	Elected 1st term	01/07/2014	30/06/2017	4 of 4
Thomas, Alan	Public	Re-elected 2nd term	01/07/2012	30/06/2015	1 of 1
Webster, Norman	Stakeholder[11]	Appointed	01/07/2011	Ongoing	4 of 4
Wickenden, Peter	Public	Re-elected 2nd term	01/07/2014	30/06/2017	3 of 4

1 As public governor representative to the QVH Charity committee until September 2015, Brian Beesley attended 0 of a possible 2 committee meetings held in 2015/16.

2 As public governor representative to the finance and performance committee from October 2015, John Belsey attended 6 of a possible 6 committee meetings held in 2015/16.

3 Representing West Sussex County Council.

4 As governor representative to the board of directors until September 2015, Brian Goode attended 4 of a possible 5 board meetings held in 2015/16.

5 As public governor representative to the QVH Charity committee from October 2016, John Harold attended 2 of a possible 2 committee meetings held in 2015/16.

6 As governor representative to the quality and governance committee, Tony Martin also attended 9 of a possible 9 committee meetings held in 2015/16.

7 As public governor representative to the finance and performance committee between June and September 2015, Chris Orman attended 3 of a possible 3 committee meetings held in 2015/16. He was appointed to the role of governor representative to the board of directors in October 2015 and has attended 4 of a possible 6 board meetings held in 2015/16.

8 Representing the League of Friends of Queen Victoria Hospital.

9 As governor representative to the audit committee since October 2015, Glynn Roche attended 2 of a possible 2 committee meetings held in 2015/16.

10 Rodabe Rudin was appointed on 1 July, 2015 and resigned on 7 August 2015.

11 Representing East Grinstead Town Council.

7.3 Directors' biographies

Ginny Colwell, Non-Executive Director

Ginny (RGN, RSCN, MA) originally trained as a nurse and worked at Great Ormond Street Hospital leaving there as deputy director of nursing to become director of nursing at the Royal Surrey County Hospital. Her next appointment was as corporate head of nursing for Nuffield Hospitals before becoming head of nursing for Surrey and Sussex Strategic Health Authority. Ginny was until recently a non-executive director at Central Surrey Health and acting chair for her last three months with the organisation. She was also vice chair of Phyllis Tuckwell Hospice until November 2013.

Dr Stephen Fenlon, Medical Director

Stephen was appointed QVH's medical director on 1 April 2013. He has been a consultant anesthetist at QVH since 2000.

He qualified in 1988 from Nottingham University Medical School and initially followed a career in general practice before deciding to specialise in anaesthesia in 1993. In addition to his clinical commitment, he has held managerial positions at QVH since his appointment, including lead clinician for paediatric services and, since 2010, clinical director for paediatrics and clinical support services.

Beryl Hobson, Chair

Beryl joined QVH in July 2014 as a non-executive director and chair designate and became chair in April 2015. She is the executive director of a governance consultancy and was previously chair of the NCT (National Childbirth Trust). She was the first chair of Sussex Downs and Weald Primary Care Trust and has more than twenty years of board level experience gained in both private, charity and NHS organisations.

Ian Playford, Non-Executive Director

Ian Playford was appointed in April 2015.

Ian is also a non-executive director of Her Majesty's Courts and Tribunal Service, board adviser to Kingsbridge Estates and runs OnBoard Executive Ltd providing strategic, investment and coaching advice to organisations.

Ian spent 20 years in the fund management, investment and development of real estate both in the UK and Europe before joining Kingfisher Plc where he was group property director, chair of its international investment committee and chair of its pension fund investment committee.

At QVH Ian is a member of the finance and performance committee.

Lester Porter, Non-Executive Director and Senior Independent Director

Lester Porter was appointed in September 2011.

He has his own executive coaching practice working with individual executives and company boards. He has also spent fifteen years as an 'angel' investor in startup businesses and held chair and non-executive director positions on the boards of a number of these companies. From 2006 until 2013 he was chair of an £800 million pension fund.

Previously, Lester spent 30 years in a variety of management roles in the healthcare, publishing, financial services and travel sectors and was latterly with the Thomas Cook Group as corporate development director.

At QVH Lester also chairs the audit committee and the charity committee.

Clare Stafford, Executive Director of Finance

Clare joined QVH in June 2015 having previously worked in senior finance roles at Hertfordshire Partnership NHS Trust and Barts and the London NHS Trust. She joined West Hertfordshire Hospitals NHS Trust in 2011 as deputy director of finance, where she was shortlisted for a Healthcare Financial Management Association (HFMA) award, before taking up the post of director of operational finance and efficiency.

Jo Thomas, Director of Nursing

Jo Thomas was appointed in June 2015 having previously held the post in an interim capacity since February 2015. Before joining QVH, Jo had held chief nurse positions in a number of commissioning and acute provider organisations.

Jo trained at Brighton University Hospitals NHS Trust and has 30 years of nursing experience in elective, specialist and emergency care, with a specialist interest and MSc in women's health. She has senior management experience of leading and managing specialist services as well as extensive experience of operational delivery and the redesign of health care services.

John Thornton, Non-Executive Director

John, from East Horsley, has almost 30 years' experience as a senior executive in the financial services industry. He currently works as an ombudsman for the Financial Ombudsman Service and is involved in a range of business and community activities as a consultant, non-executive director and mentor.

At QVH John chairs the finance and performance committee of the board of directors.

Richard Tyler, Chief Executive

Richard Tyler has over twenty years of experience gained in a variety of posts across the NHS.

Richard joined QVH as chief executive in July 2013. He was previously chief executive at Hounslow and Richmond Community Healthcare NHS Trust. Richard has held roles in operational management, business and performance management and strategic planning within acute trusts, primary care trusts and at strategic health authority level.