Queen Victoria Hospital
NHS Foundation Trust

QUEEN VICTORIA HOSPITAL
NHS FOUNDATION TRUST
Annual Report and Accounts 2019/20

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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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1 Introduction

Chair's introduction
I am pleased to present the 2019/20 annual report and accounts for Queen Victoria Hospital NHS Foundation Trust (QVH).

QVH is an exceptional hospital. We are the second smallest trust in England but our reputation stretches around the world. That is the result of the high quality services, innovation and partnership working at the core of our clinical work.

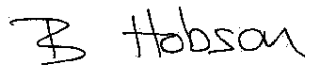
In 2019 Care Quality Commission inspectors noted that our staff were highly motivated and inspired to offer care that was exceptionally kind and promoted people's dignity; and that relationships between patients and staff were strong, caring, respectful and supportive. At QVH we work hard to promote and maintain this standard of care and our staff are rightly proud of the way they genuinely go above and beyond for patients.

In the last two months of 2019/20 the COVID-19 pandemic changed ways of working across the NHS, with QVH rapidly establishing a key role as a cancer and trauma centre, ensuring patients needing our services could continue to be treated. As you will read in this report, before the pandemic QVH was facing significant financial challenges but our management of waiting lists was strong; the pandemic impacted heavily on planned surgery at QVH and in every other hospital.

It is testament to the dedication of all our staff that our clinical outcomes remain excellent, feedback from our patients remains overwhelmingly positive and we continue to deliver the very best care for our patients.

At the time of writing we are exploring whether joining a hospital group could help us to do even better for our patients and our staff in the future. We want to maintain the very best clinical outcomes while making sure we can run resilient patient-facing and back office services; ensuring our specialist services are backed up by the full range of support services, and optimising the use of NHS resources. QVH has a strong track record of working in partnership and we continue to work with providers and commissioners across the region in a collaborative and networked approach to providing care.

I would like to thank our staff, volunteers, governors and board members for all that they do to make sure our work reflects our values of humanity, pride and continuous improvement, and that QVH remains a wonderful place to work and a truly exceptional place to receive treatment.



Beryl Hobson
Chair

22 June 2020

2 Performance

a) Overview of performance

Statement from Chief Executive

It is difficult for a report on 2019/20 not to be coloured by the events in the final months of the financial year due to the COVID-19 pandemic. The first impact was patients cancelling clinic and surgery appointments amid concerns about the spread of the virus, and this was followed by an NHS-wide decision to cancel non-urgent operations and prepare for a potential surge of patients needing hospitalisation and critical care.

I am incredibly proud of how hard the team at QVH worked through late March and April 2020 to agree the role of QVH in the wider NHS system and to implement that. QVH was designated as a surgical referral centre for head and neck, breast and skin cancers for the south east, and in parallel with that, through close working with the independent provider on our East Grinstead site we were able to continue to provide urgent trauma treatment to adults in our areas of specialism (maxillofacial, hands and eyes). To protect our patients and our staff from COVID-19 we put in place new systems and processes; trained staff in new skills and safe use of personal protective equipment; and with a strong work stream of IT support, set up the majority of our back office staff to work from home and those still on site to work with social distancing.

At the time of writing COVID-19 is still a very real concern for the NHS and the UK as a whole, but as we move into restoration and recovery we are looking carefully at how we build on some of the benefits achieved in such a rapid programme of transformation. Foremost among these is the establishment of virtual clinics, a safe and effective way for clinicians and patients to have appointments by video or phone, fully linked to our patient information systems, without the need for the patient to travel. As a regional and national provider of specialist services some of our patients make very long journeys for appointments.

One of the significant achievements in 2019/20 was the robust management of QVH waiting lists, with staff working on the detail of every patient journey to deliver a 17% decrease in total number of patients waiting between April 2019 and March 2020. The intense focus on individual patients waiting over 52 weeks meant that pre COVID-19 the Trust was on track have fewer than ten of these exceptional long waiters by March 2020, the majority of whom had made the choice to delay their surgery.

Results from national patient surveys in 2019/20 placed QVH amongst the top performing hospitals in the country. In NHS England's National Cancer Patient Experience Survey patients rated highly the cancer care they receive at QVH, saying they were involved in decisions and treated with dignity and respect. In the Care Quality Commission's survey of children and young people, QVH was the only trust in the country to achieve the top score in both the 0-7 year old and the 8-15 year old categories. In the national survey of adult inpatients QVH also received exceptionally positive feedback. Patients answering a wide range of questions about the care and support they received confirmed that we treat every patient as an individual and give them the care and attention that they need. Things like having the time to ask questions and receive emotional support matter just as much as the excellent clinical outcomes for which QVH is also known. Going into hospital is not something that most of us would want, and it is a great tribute to the care and compassion of our staff that the vast majority of our patient are able to say they had 'a very good experience'.

Results from the latest national survey of NHS staff show that staff at QVH rate it highly as a place to work as well as confirming that it is an excellent hospital to receive treatment. The detail of the QVH staff response is in section 3 of this report, and shows

that the results in most areas have increased on last year's survey. We are especially proud to score so highly for staff morale, the highest in our benchmarking group, because the association between staff morale and patient care is clear.

We are proud of our learning culture and the opportunities we give our staff throughout the organisation to develop their skills and careers. Our apprentices and nursing associates are able to study and train whilst they earn. Our team leaders and managers are supported with personal development and training for everything from writing business cases to having meaningful conversations in appraisals. In an NHS where recruitment and retention is a significant challenge, we continue to devote considerable effort to ensuring that we attract and retain the very best staff.

For the last three years we have been facing significant financial challenges, and are addressing the many and complex solutions to the simple fact that our income and our costs do not balance. In 2019/20 the Trust has drawn on cash support from the Department of Health and Social Care as set out in note 1.1 to the accounts, where the Trust discloses the material uncertainties around its future financial position, and in section 3.7 of this report.

In 2019/20 the pension tax issue had a particular impact on the availability of our consultant workforce to deliver additional clinical sessions and therefore a negative impact on the Trust's income and waiting list. This is an issue not just of finances but also of long-term workforce planning; we need our highly skilled, senior, experienced doctors to train and develop others.

We are currently considering whether being part of a hospital group could help with our long term financial sustainability in supporting a strategic approach to which services are best provided on which hospital site, the efficiencies of working together and transformation in the way the NHS delivers services. A hospital group could also support our workforce. Our size means that in a number of areas we have just one person who is responsible for a role in the organisation. This provides us with challenges to cover periods of work pressure, annual leave, sickness and gaps between members of staff leaving the Trust and new recruits coming in. A hospital group could give key individual staff the back up of a wider team, and provide more opportunities for staff who want to progress in their careers.

We have been discussing these challenges with our stakeholders and our staff for some time. Whatever structural decisions we make, I am confident that our board and our governors will remain focussed on maintaining and building on our excellent record for patient experience, clinical outcomes and safety, and securing the future of the hospital in East Grinstead.

QVH is an exceptional hospital with amazing staff. I want to publicly record my personal thanks to all our staff. Whether working face to face with patients or behind the scenes in our support services, our staff continue to go above and beyond for our patients and deserve to feel proud of all that they have delivered this year.

Statement of the purpose and activities of the Foundation Trust

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, 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 multidisciplinary teams throughout the region.

In 2019/20, 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 disorder services
- a wide range of therapy services and community-based services
- a minor injuries unit.

QVH operates a networked model from its 'hub' hospital site in East Grinstead, West Sussex. Reconstructive surgery services (a mix of planned surgery and trauma referrals) are provided by QVH in 'spoke' facilities at other major hospital sites across Kent, Surrey and Sussex. These include services provided at the sites of the following trusts:

- Brighton and Sussex University Hospitals NHS Trust
- Dartford and Gravesham NHS Trust
- East Sussex Healthcare NHS Trust
- East Kent Hospitals University NHS Foundation Trust
- Kent Community Health NHS Foundation Trust
- Maidstone and Tunbridge Wells NHS Trust
- Medway NHS Foundation Trust
- Surrey and Sussex Healthcare NHS Trust.

QVH also receives referrals from these hospitals.

In addition, QVH provides community-based clinical services into which GPs can refer, based on a range of sites across Kent and Sussex.

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 public members in Kent, Surrey, Sussex and the boroughs of South London.

Key issues, opportunities and risks that could affect the Foundation Trust in delivering its objectives and/or its future success and sustainability
The Trust has a strategy called QVH 2020: Delivering Excellence. It has developed its strategic emphasis across five domains of excellence, which comprise the following key strategic objectives. These are set out below and include details of the principle risks identified in each case.

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

The principle risk to delivery of this objective is the ability of the Trust to recruit and retain the right staff with the specialist skills required for caring for all our patients. We have had

significant success in 2019/20 in attracting high quality staff through UK and international recruitment.

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, training and innovative research and development.

As a specialist surgical hospital, without co-located general medical, paediatric and diagnostic services, we must constantly review our admission and discharge criteria, our adherence to safety standards, and our clinical partnerships with neighbouring trusts to ensure we are providing a safe, effective service, particularly outside of normal working hours.

We have recently appointed a joint post in maxillofacial surgery with Brighton and Sussex University Hospitals NHS Trust and plan to appoint a joint head and neck cancer post shortly. In addition, three ortho-plastics posts were recently jointly appointed with Brighton and Sussex University Hospitals NHS Trust. These linked posts will strengthen our clinical networking strategy in the region.

3. Operational excellence
We provide services that ensure that patients are offered choice and are treated in a timely manner

The principle risks to delivery of this objective are the availability and capacity of specialist clinical staff across our sites and the impact of pension taxation on medical capacity.

The Trust is working collaboratively with other providers to support waiting times across the NHS locally. We are also considering whether being part of a hospital group and working closely with NHS commissioners could help us to develop a clear future strategy for our services benefiting patients across the region. There may be opportunities for QVH to support other hospitals with rapid diagnostics such as CT and MRI scanning.

4. Financial sustainability
We maximize existing resources to offer cost effective and efficient care whilst looking for opportunities to grow and develop our services.

As a stand-alone organisation we must meet the same requirements for standards and reporting as a much larger organisation. This leads us to having a disproportionate level of overhead costs for the income we receive for the services we provide. Historically we have met our financial targets but in recent times this has become more challenging. Given the small size of the organisation, fluctuations in the money we receive for services provided (tariff), workforce costs and a change in number and type of patients we see, can disproportionately affect our ability to meet our financial plans.

As described elsewhere in this report we are considering the opportunities for a hospital group model to support our work, including financial sustainability.

5. Organisational excellence
We seek to be the best place to work by maintaining a well led organisation delivering safe, effective and compassionate care through an engaged and motivated workforce.

During 2019/20 the board agreed updated wording for this objective to reflect action taken to make QVH 'the best place to work' including a significant online conversation with staff in June 2019 and the follow up to that.

During the year we reduced the risk rating slightly based on the success of our overseas recruitment campaign which has improved the number of nursing and operating department practitioners in post considerably; annual rolling turnover decreased by around 5% in year and bank and agency use reduced significantly. Sustained work on our recruitment and retention plan has also been positively reflected in the staff survey scores for 2019 as described elsewhere in this report.

Going concern
These accounts have been prepared on a going concern basis.

The Trust is required under International Accounting Standard 1 to undertake an assessment of the NHS Foundation Trust's ability to continue as a going concern. Due to the materiality of the financial deficit, the Board has carefully considered whether the accounts should be prepared on the basis of being a going concern.

The board considered that the definition of going concern in the public sector focuses on the expected continued provision of services by the public sector rather than organisational form. The financial statements of all NHS providers and clinical commissioning groups will be prepared on a going concern basis unless there are exceptional circumstances where the entity is being or is likely to be wound up without the provision of its services transferring to another entity in the public sector.

The factors taken into consideration are set out below.

Control total
The 2020/21 financial control total for the Trust issued on 4 October 2019 from NHS Improvement is that the Trust should breakeven with no support from the Financial Recovery Fund. The control total was set on the basis of 2018/19 control total, which had not been accepted by the Trust board, and did not reflect the material deterioration in the Trust's financial position or the 2018/19 and 2019/20 year-end positions. The Trust has therefore not been able to accept the allocated control total for 2020/21 and was forecasting a draft deficit in 2020/21 of £8.7m based on the business planning guidance pre COVID-19. Due to the change in guidance the forecast year end position is unclear for 2020/21, however at present the cumulative deficit for the prior two years remains at £13.3m.

Year-end contract agreements for 2019/20
In March 2020 in line with national guidance all non-urgent elective operations were to free-up the maximum possible inpatient and critical care capacity as part of the COVID-19 response requirement. After the year-end agreements were put in place with commissioners to protect the Trust against loss of income from this reduction in elective activity. The Trust was on Payment by Results contracts with commissioners in 2019/20, and agreements were reached with all contract commissioners to fund the Trust to year-end based on the January and February 2020 activity forecast outturn. Payments were also provided centrally to cover the costs of COVID-19 related work carried out during 2019/20 which included funding any loss of income for non-contract activity.

Contracts for 2020/21
The operational planning process and contracting round has been suspended for 2020/21 and amended financial arrangements have been put in place due to COVID-19 preparations.

For 2020/21, NHS England is providing a guaranteed minimum level of income reflecting the Trust's current cost base until 31 October 2020 – an annualised £66.5m. This is based on the average monthly expenditure implied by the Trust's December 2019

Agreement of Balances return and includes an uplift for inflation without any tariff efficiency factor being applied.

Prior to the suspension of planning in February 2020, the Trust submitted a draft operating plan based on 2019/20 demand and capacity. The guaranteed block income received from NHS England for 2020/21 is in line with the commissioner income included in the draft operating plan, excluding planned income from waiting list initiatives and commissioner notice items relating to proposed tariff increases.

The block funding will not be revised to reflect any short falls in normal contractual performance until at least 31 July 2020 and all contract sanctions are suspended. The Trust will also be able to claim monthly for additional costs where block payments do not equal actual costs to reflect genuine and reasonable additional marginal costs due to COVID-19. Examples of this would include increases in temporary staffing to cover increased levels of sickness absence, or increased non-pay costs in dealing with COVID-19 activity.

Non-England (any activity outside of Department of Health and Social Care scope, including Wales and Scotland), non-contract activity in 2020/21 is likely to be impacted by elective activity reductions for at least the first four months of the year. The Trust will continue to invoice separately for this, and for services provided to other NHS providers, on the basis of amounts invoiced in 2019/20 without any inflationary uplift, regardless of level of service provided. A national top-up payment will be provided to reflect the difference between actual costs and non-contract, non-England income, where the expected cost base is higher.

These provisions are in place with an overall aim of ensuring the Trust reaches a break-even position during the first seven months 2020/21. The Financial Recovery Fund and associated rules are also suspended during this period.

The financial regime post-31 October remains uncertain at this stage due to the unpredictability of the demand on the system for the treatment of COVID-19 patients. Further guidance is awaited as to when the planning process will recommence.

Service provision in 2021/22 and beyond
Looking further ahead, the Trust has reasonable expectations that services will continue to be provided by QVH in 2021/22. As part of the response to the pandemic, QVH has taken on the role of being the cancer surgery hub for Kent, Surrey and Sussex for head and neck, skin and breast cancer patients. It is expected that significant elective activity in these specialist areas will be required as part of the restoration and recovery period following the pandemic. In the longer term, the Trust is considering whether being part of a hospital group could help with its long term financial sustainability.

Cost improvement and efficiency plans
Due to the block contract arrangement, the Trust is not required to develop and deliver efficiency plans over the block contract time period, however due to the Trusts deteriorating financial position and the requirement to achieve break even in the coming years the Trust is pushing forward with efficiency plans. At present £0.6m of efficiencies for 20/21 have been identified against a target of £1.2m (2019/20 achieved £1.2m against a target of £1.8m), however the risk remains that the spending and activity patterns of the Trust have changed so significantly that the pre COVID-19 identified plans may, at present, not be achievable.

Cash flow
The Trust expects to receive cash support in line with the block contract arrangement until at least 31 October 2020, in line with the statement from NHS England and NHS Improvement to support provider and commissioner forecasting. The Trust is awaiting

central guidance as to the cash flow support which will be available post block contract arrangements. Due to the Trust's material deficit, the Trust will need significant on-going cash support for the 12 month period from the date of approval of these accounts which is undetermined at present and unconfirmed but is expected to be material.

Loans

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. Given this relates to liabilities that existed at 31 March 2020, DHSC has updated its Group Accounting Manual to advise this is considered an adjusting event after the reporting period for providers.

Outstanding interim loans totalling £6.4m as at 31 March 2020 in these financial statements have been classified as current as they will be repayable within 12 months.

The loans received for the theatre build totalling £10.1m are not affected by the reforms described above and will remain due. Payment terms remain the same as the loan agreement dated 20 June 2011, 3.85% of the principal debt repayable every 6 months from December 2013 to June 2026.

Key risks to the financial plan

The key risks to the financial plan are based in the high level of uncertainty in the current pandemic situation. This includes:

- Block contracts have been agreed to 31 October 2020, but it is unlikely that health services will be able to operate in a normal way at this stage. The increased levels of PPE and screening of patients significantly reduces the efficiency of theatre activity, and national instructions on the stratification of elective work to prioritise clinical need will impact on case mix. If the block contract comes to an end in year, these factors will have an impact on income which it is not possible to assess at this stage.

- There is uncertainty as to the continuation of the national contract with the independent sector. This contract is currently supporting the separation of trauma and cancer patients on the East Grinstead site. If the Trust is unable to make use of the independent sector facilities there will be a significant impact on activity.

- Ongoing work across the Sussex Health and Care Partnership (integrated care system) and through the cancer networks as part of the pandemic recovery work may lead to in year changes in which services are provided by QVH.

- In the suspended business planning guidance 1.6% of efficiencies were required for trusts in deficit. For QVH this would be £1.2m. At present £0.6m have been identified and £0.6m is unidentified. The Trust is mindful that the identified efficiencies may not materialise in year due to differing spending patterns under the current activity arrangements.

- Uncertainties around the impact of Brexit on the cost of pharmaceuticals, medical devices and potential impact on the NHS workforce.

The Trust still faces a material deficit based on the original 2020/21 business planning guidance for tariff. This year the Trust was anticipating Financial Recovery Funding through the Sussex Health and Care Partnership, however due to the current arrangements this is not required but will still be a requirement post block contract arrangements.

Directors' statement regarding going concern

After making enquiries, the directors have concluded that there is sufficient evidence that services will continue to be provided. In reaching this conclusion, the board considered the financial provision within the forward plans of commissioners; efficiency plans and the recognised role of the Trust within the Sussex Health and Care Partnership and the wider regional health care system. The Trust's cash flow provision will be dependent on both acceptance and delivery of the financial recovery plans and support from the Department of Health and Social Care (DHSC). As with any Trust placing reliance on other DHSC group entities for financial support, the directors acknowledge that there can be no certainty that this support will continue although, at the date of approval of these financial statements, they have no reason to believe that it will not do so.

Based on these indications the directors believe that it remains appropriate to prepare the accounts on a going concern basis. However, the matters referred to above represent a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern and, therefore, to continue realising its assets and discharging its liabilities in the normal course of business. The financial statements do not include any adjustments that would result from the basis of preparation being inappropriate.

2.2 Performance analysis

How we measure performance
Queen Victoria Hospital (QVH) measures performance against a range of key indicators that include access targets, quality standards and financial requirements. Priority indicators are those included within the NHS Improvement *Single Oversight 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 which is used to hold to account and support the relevant directorates and managers. 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. The panel meets with the relevant clinical directors, business unit managers, and human resources and finance business partners, to review each directorate's performance.

Assurance is provided to the board via the finance and performance committee and also the quality and governance committee 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. This includes 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

The board is assured, as recorded in the annual effectiveness review considered in March 2020 that an effective governance structure is in place to enable and support QVH to meet its strategic objectives, and ensure compliance with regulatory requirements. The governance structures are fit for purpose and in line with best practice in the NHS and other sectors.

In July 2019 the board conducted an annual review of the standing orders and standing financial instructions, the reservation of powers and scheme of delegation.

A process is in place for the regular review of effectiveness and adequacy of board committees, including terms of reference and work plans. This programme supports the board's annual evaluation of its own performance. The process of board subcommittee reviews has resulted in minor changes to terms of reference and internal processes.

Foundation Trust boards are required to undertake an external review of governance every three years to ensure that governance arrangements remain fit for purpose. During 2017/18 we appointed an external team to carry out this review. In each of the eight 'key lines of enquiry' QVH demonstrated areas of good practice as well as areas for improvement. As a result QVH has strengthened board reports; developed a board staff engagement plan to record the activity of board members in meeting with staff outside of their functional role; and revised the role description for governors on committees to ensure clarity about their involvement.

Care Quality

The Care Quality Commission (CQC) undertook an unannounced inspection of the Trust in January 2019 and a Well Led inspection in February 2019. This included a review of three of the core services offered by QVH. The overall rating for the hospital is 'Good' with a rating of 'Outstanding' for care. Improvements in the critical care unit mean each individual service at QVH, as well as the Trust as a whole, are now rated as 'Good'.

The Trust received no other unannounced CQC inspections during 2019/20. The CQC relationship manager meets with the Trust on a 1-2 monthly basis. The Trust undertakes 6 monthly compliance in practice visits to all clinical areas to assess the quality of care against the fundamental CQC core standards.

The Trust is fully compliant with the registration requirements of the CQC.

Infection control

QVH had two hospital acquired cases of Clostridium difficile, one E. Coli bacteraemia and two hospital acquired MRSA bacteraemia in 2019/20.

Waiting times

In 2019/20 QVH implemented a recovery plan to improve the delivery of referral to treatment standards. Before the onset of the COVID-19 pandemic, waiting times improved overall with a reduced total waiting list size, and increased open pathway performance. The Trust reduced the number of patients waiting over 52 weeks and of the residual number the majority were patients who had chosen to delay their surgery.

The COVID-19 pandemic meant in quarter four a number of planned operations were cancelled by the hospital in order to prepare for changed working, and by patients who were anxious about coming to hospital. The impact of the pandemic on waiting times in 2020/21 will be significant.

	Q1	Q2	Q3	Q4
Patients waiting greater than 52 weeks	39	25	15	18
Referral to treatment within 18 weeks Target 92%	80.9%	81.6%	82.8%	78.5%
Total waiting list size	11309	10516	10429	10123

Figures shown are month end for each quarter

Cancer waiting times

Throughout 2019/20 QVH worked to improve cancer times for patients. An improvement plan is in place across all constitutional standards and before the COVID-19 pandemic the Trust made good progress in preparing for the new faster diagnosis standard.

	Q1	Q2	Q3	Q4
Patients beginning first definitive treatment within 62 days following urgent GP referral for suspected cancer	85.5%	86.7%	82.1%	84.7%
2 week wait referral for suspected cancer	92.4%	92.8%	91%	94%

Figures shown are calculated using the total number of treatments each quarter and the total number of breaches each quarter

Financial Plan

The Trust was issued a control total in January 2019 for the year 2019/20 of £0.5m surplus, including a non-recurrent provider sustainability fund (PSF) allocation of £0.7m. The Trust did not sign up to this control total and resubmitted a plan in line with the financial deterioration in 2018/19 of £7.2m deficit (including £0.2m of donated asset adjustments).

The year 2019/20 was a particularly challenging year for the Trust's finances. The Trust delivered a deficit of £9.1m for the year. This was driven principally by a shortfall of activity; activity levels reached around 2018/19 levels but with a significant investment in staffing.

There was a shortfall of £0.6m against the cost improvement target of £1.8m. The Trust delivered the required 1.6% (£1.2m) cost improvement target. There were significant expenditure pressures incurred delivering activity in year. In the context of these challenges, in January 2020 the Trust submitted a reforecast of £9.2m deficit, reflecting the under delivery on income as compared to the original plan.

The key financial financial performance indicators for 2019/20 are detailed in the table below.

2019/20 key financial performance indicators	Plan £000	Actual £000
Reported financial performance	£9,205	£9,141

The control total reported above reflects the Trust submitted control total to NHS Improvement and NHS England and not the control total required from NHS Improvement and NHS England. Reported financial performance (based on guidance pre COVID-19) of £9.1m retained deficit includes a revaluation net impairments of trust

assets of £0.4m. The performance of the Trust is assessed by regulators before the impact of revaluation on the income and expenditure account. The overall income and expenditure position, as detailed in the statement of comprehensive income set out in the accounts (section 6) is a deficit of £8.2m. This included the effect of revaluation adjustments to the income and expenditure account and the revaluation reserve.

Statement of comprehensive income
Below is an extract of the table from the accounts (section 6) that shows the total value for income and expenditure for the financial year.

	£000
Operating income from patient care activities	69,052
Other operating income	3,347
Operating expenses	(80,006)
OPERATING SURPLUS / (DEFICIT)	**(7,607)**
NET FINANCE COSTS	**(1,549)**
Other gains/(losses)	15
Retained SURPLUS/(DEFICIT) FOR THE YEAR	**(9,141)**
Other comprehensive income	
Revaluations	4,159
Impairments	(3,189)
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE PERIOD	**(8,171)**

An independent professional valuer completed a full revaluation of all land, buildings and fixtures in-year. There was a £0.6m increase in the assets' values arising from the revaluation exercise. Revaluations of £1.0m were recognised in the revaluation reserve and there was a £0.4m net impairment charge for revaluation to the income and expenditure account.

Income
Total income for the Trust was £72.4m. The Trust received £69m, the majority of its income, from the provision of patient care activities. In addition, the Trust received other operating income of £3.3m this includes £1.8m from Health Education England to support the cost of providing training and education to medical and other NHS staff, other contract income of £0.8m, and £0.6m of capital grants and donations.

Operating expenses
The Trust incurred £80m of operating expenses in 2019/20. This includes costs of £53m (66% of total operating expenditure) to employ, on average over the year, 991 members of staff. This includes £2.8m for agency/contract staff and £0.2m for the apprenticeship levy.

Operational non-pay expenditure includes supplies and services costs of £12.7, drug costs of £1.4m, premises costs of £3.5m, depreciation and amortisation of £3.4m , transport costs (including patient travel) of £0.6m, clinical negligence premium of £0.8m and impairment due to revaluation of £0.4m.

Capital
Capital expenditure equated to £4.4m in 2019/20, materially in line with the agreed plan after allowance for the capitalisation of a finance lease (£0.4m). The table below details the investments made.

Capital programme 20 19/20	£000
Building and infrastructure	1,139
Medical Equipment	953
Information, Management and Technology	2,343
Total	**4,435**

Cash
The Trust has a cash balance of £2.9m, which represents c.13 days of operating expenditure. The majority of funds are held with the Government Banking Service (GBS).

Environmental and Sustainability Report
As a Trust, we recognise our responsibility for environmental protection and the requirement to contribute to the delivery of national sustainable development targets.

The key sustainability objectives are:

- To continue to reduce our carbon footprint year on year through behavioural change and introducing low carbon technologies
- To embed sustainability considerations into our core business strategy
- To procure goods and services in a sustainable manner
- To work with other NHS organisations in the Sussex Health and Care Partnership on our shared carbon reduction process
- To eliminate single use plastics in our general day-to-day operation in line with NHS England directions
- To reduce both general and clinical waste in line with NHS England directions.
- To consider the design and operation of our buildings
- To implement phased action plans to address energy, water and carbon management reduction programmes, including the use of grey water systems and sustainable drainage systems on the hospital estate.

In 2019/20 key successes included:

- Completion of our programme to install variable speed drives to larger fan motors and the installation of more energy efficient plant and building controls
- Our ongoing programme of upgrading aged and inefficient plant, including the installation of energy efficient condensing boilers
- Completion of the programme of work to replace existing lighting with low energy and low maintenance LED versions within the main hospital and critical areas.
- Significant reductions in food waste due to changes within our catering
- An improvement in the accuracy of our data for waste through tonnage reports for the different streams of waste from our providers, with an overall decrease in waste and associated CO2 figures

Our carbon footprint

Our carbon footprint from gas and electricity sources during 1 April 2019 to 31 March 2020 was 2,245 tonnes of CO_2 equivalent.

Greenhouse gas emission data for period:	01 April 2019- 31 March 2020
Emissions Source	Tonnes of CO_2e
	Current reporting year
Combustion of fuel and operation of facilities	1,177
Electricity, heat, steam and cooling purchased for own use	1,068
Total	2,245

Total energy consumption was as follows:

Energy type	Annual (kWh)
Gas	6,400,387
Electricity	4,178,748

Around 60% of total energy consumption is associated with heating and hot water, with the remaining energy use split between lighting, ventilation, air conditioning, small power and pumps.

Energy consumption by building and by service:

		Gas	Electricity							
	GIA	kWh/Year								
Building/Area	**GIA**	**Heating**	**DHW**	**/entilatio**	**Conditior**	**Lighting**	**mall Powe**	**Pumps**	**Total**	**%**
Jubilee Centre and Minor Injuries Unit	2146.5	264,044	168,539	0	2,328	152,596	100,869	3,362	2,383,266	23.24%
Rehabilition, Estates and Hotel Services	1176	390,529	102,070	0	0	18,111	54,332	2,868	1,965,469	19.71%
Macmillan Information & Support Centre and Prosthetic Clinc	863.1	197,523	159,642	0	5,211	12,738	39,371	0	988,790	9.64%
Physio / Occupational Therapy	423	79,250	63,833	0	0	3,895	20,206	0	837,261	9.61%
Main Out Patients Modulars	792	97,632	132,691	0	37,877	2,821	35,459	3,062	691,737	6.75%
Canadian Wing and Pharmacy	2697	294,614	147,307	0	12,857	257,132	120,530	4,821	567,910	5.54%
Day Surgery	397.3	69,003	51,472	0	0	5,827	17,967	97	446,134	4.35%
American Wing and Rowntree Theatres	4077.6	747,538	557,687	0	161,035	315,360	181,165	2,684	414,485	4.04%
Burn Unit	1715	310,515	231,655	276,027	6,335	85,976	76,926	1,358	407,263	3.97%
Peanut	649	114,811	77,407	0	4,043	28,878	29,520	1,219	309,543	3.01%
Paeddiatric Assessment Unit	167	28,003	19,802	0	0	2,451	7,660	0	255,879	2.49%
Medical Photography	193.3	33,603	21,602	0	0	2,829	8,840	0	215,499	2.10%
Admissions / Speech Therapy	158.7	0	115,365	0	0	2,332	7,288	0	167,184	1.63%
Blond McIndoe Research Building 18-19	724	135,893	92,366	163,968	13,477	8,985	31,446	0	154,930	1.51%
New Theatre	4415.3	445,756	545,953	826,714	165,343	151,564	192,900	55,036	144,367	1.41%
Corneo Plastic Clinic	498	86,808	59,406	0	3,289	43,391	22,395	210	124,985	1.21%
Kitchens	1024.2	266,270	64,644	12,440	0	14,772	46,649	2,488	85,248	0.83%
Surgeon's Mess and Health Records Stores	363.7	88,757	30,621	0	0	18,426	16,259	867	66,874	0.65%
Gardens Store	100.8	26,627	0	0	0	1,474	4,606	0	57,916	0.56%
Staff Development Centre	502	24,628	30,225	0	0	7,368	23,026	0	32,706	0.31%
Hurricane Café	60.3	11,201	0	0	0	878	2,743	0	14,822	0.14%
									47,528	
Total GIA	23143.8									
Sub-Total		3,713,005	2,672,288	1,279,148	411,794	1,137,804	1,040,157	78,073		
Totals		6,385,293		3,946,976						

The largest proportion of energy use (23%) is associated with the theatre complex.

Energy Consumption by building is described below:

Figure2.

Building/Area	Total	%
Theatre block	2,383,266	23.24%
American wing and day surgery theatres	1,965,469	19.71%
Burns unit	988,790	9.64%
Canadian wing and pharmacy	837,261	9.61%
Jubilee building and minor injuries unit	691,737	6.75%
Rehabilitation building, estates and hotel services	567,910	5.54%
Eye bank and laboratories	446,134	4.35%
Macmillan information & support centre and prosthetic clinic	414,485	4.04%
Kitchens	407,263	3.97%
Outpatients building	309,543	3.01%
Peanut (children's ward)	255,879	2.49%
Corneoplastic clinic	215,499	2.10%
Physio and occupational therapy	167,184	1.63%
Day surgery	154,930	1.51%
Surgeon's mess (all staff) and health record stores	144,367	1.41%
Admissions and speech therapy building	124,985	1.21%
Learning and development centre	85,248	0.83%
Medical photography	66,874	0.65%
Paediatric assessment unit	57,916	0.56%
Gardens Store	32,706	0.31%
Hurricane café	14,822	0.14%

Specific carbon reducing projects identified for implementation in 2020/21 are:

- Review and reduction of overnight electricity consumption in theatres
- Continued installation programme of variable speed drives to larger fan motors, connected to the building management system so efficiency gain can be calculated
- Review of the building management system, seeking opportunities for carbon reduction
- Continuation of the programme to replace existing lighting with low energy and low maintenance LEDs
- Full participation in sustainability and transformation partnership (STP) carbon efficiency scheme review.

<u>Waste reduction and recycling</u>

Recycling facilities are available across QVH and we continue to work to improve waste segregation.

Waste recycling

Waste		2015/16	2016/17	2017/18	2018/19	2019/20
Recycling	(tonnes)	0	0	68	187.3	33.76
	tCO_2e	0	0	1.43	3.93	1.76
Other recovery	(tonnes)	129	106	155	42.78	81.2
	tCO_2e	2.71	2.12	3.26	0.89	1.78
High Temp disposal	(tonnes)	0	0	0	0	0
	tCO_2e	0	0	0	0	0
Landfill	(tonnes)	44	44	85	0	0
	tCO_2e	10.75	10.75	26.35	0	0
Total Waste (tonnes)		173	150	308	230.08	114.96
% Recycled or Re-used		0%	0%	22%	81%	100%
Total Waste tCO_2e		13.46	12.87	31.03	4.83	3.54

Social and community issues

QVH maintains close connections with the local community in East Grinstead and the surrounding areas, including regularly sharing information through the local press and on social media. Almost half of our c.7,400 foundation trust members have provided the Trust with an email address which enables us to keep them up to date in real time, electronically. A presentation has been developed by governors which they use to provide information on the work of the Trust and its services to clubs, societies or groups within the local community. All governors are invited to participate in this initiative.

QVH seeks to remain relevant to the local community in East Grinstead as well as the wider community through the provision of services. In addition to the minor injuries unit, the hospital provides rapid assessment and treatment through a number of community services including rheumatology and cardiology clinics. Our specialist Parkinson's disease nurse visits patients at home as well as in clinic, and our partnership with the Royal Alexandra Children's Hospital in Brighton means that younger patients can be treated for many common ailments without needing to travel further afield.

QVH is a member of the Sussex Health and Care Partnership which in April 2020 became an integrated care service in line with the Government's Long Term Plan. As a specialist trust and as a key service provider for our local community, we recognise the value of strong collaborative relationships with local GPs and other health and social care providers for the benefit of our population. Regular and open dialogue with stakeholders such as Healthwatch West Sussex gives us an additional method for ensuring we are involving and responding to our local community.

Anti-bribery and human rights issues

The rules and procedures relating to bribery are set out in the counter fraud policy, and those relating to the provision or receipt of gifts or hospitality are set out in the Trust's standards of business conduct policy. The Trust maintains a register of gifts, hospitality and sponsorship received and staff are made aware of the need to declare any potential conflict of interest**.**

Protecting the vulnerable and those at risk is a key component of our trust objectives. Focussing on quality and patient experience we work alongside partner agencies to promote the safety, health and well-being of people who use our services. The QVH Safeguarding strategy includes a Human Rights Framework to make transparent protection of vulnerable patients at QVH.

Policies and procedures which relate to the Trust's corporate responsibility for slavery and human trafficking are reviewed and updated regularly.

The procurement team work with the NHS terms and conditions which require suppliers to comply with relevant legislation. Procurement frameworks are also often used in the Trust to procure goods and services, under which suppliers adhere to a code of conduct on forced labour. Relevant pass/fail criteria have been introduced on procurement led tenders and quotations not conducted via a framework.

The Trust has not been informed of any incidents of slavery or human trafficking during the year. In the event of a slavery or human trafficking incident occurring or an allegation being made the matter will be reported and investigated using the Trust's safeguarding procedures to determine appropriate action.

Important events since end of financial year
The COVID-19 pandemic had a significant impact at and after the end of the financial year. The first impact was patients cancelling clinic and surgery appointments amid concerns about the spread of the virus, and this was followed by an NHS-wide decision to cancel non-urgent operations and prepare for a potential surge of patients needing hospitalisation and critical care.

Our staff worked through late March and April 2020 to agree the role of QVH in the wider NHS system and to implement that. QVH was designated as a surgical referral centre for head and neck, breast and skin cancers for the south east, and in parallel with that through close working with the independent provider on our East Grinstead site we were able to continue to provide urgent trauma treatment to adults in our areas of specialism (maxillofacial, hands and eyes).

The number of patients treated in the first months of 2020/21 through the new processes we put in place and with safe use of personal protective equipment, was considerably lower that would have been expected under normal conditions. The Trust was funded through a block contract rather than the previous activity based payments.

Overseas operations
QVH has no overseas operations

Steve Jenkin
Chief Executive and Accounting Officer
22 June 2020

3 Accountability

3.1 Directors report

Directors' disclosures
In 2019/20 the following individuals served as directors of Queen Victoria Hospital NHS Foundation Trust.

NAME	POSITION
Beryl Hobson	Chair *(voting)*
Paul Dillon-Robinson	Non-executive director from 01/10/19 *(voting)*
John Thornton	Non-executive director and senior independent director to 30/09/19 *(voting)*
Ginny Colwell	Non-executive director *(voting)* to 20/04/19
Kevin Gould	Non-executive director *(voting)*
Karen Norman	Non-executive director *(voting)* from 08/04/19
Gary Needle	Non-executive director and senior independent director from 01/10/19 *(voting)*
Steve Jenkin	Chief executive *(voting)*
Michelle Miles	Director of finance and performance *(voting)*
Keith Altman	Medical director from 01/10/19 *(voting)*
Lucy Owens	Interim director of finance and performance from 03/02/20 to 26/03/20 *(voting)**
Ed Pickles	Medical director to 30/09/19 *(voting)*
Jo Thomas	Director of nursing & quality *(voting)*
Abigail Jago	Director of operations *(non-voting)*
Geraldine Opreshko	Director of Workforce and organisational development *(non-voting)*
Clare Pirie	Director of Communications and corporate affairs *(non-voting)*

* To cover a period of planned absence of Michelle Miles, director of finance and performance

Biographies for all current directors of the Trust are provided in section 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. These are available in full from the Queen Victoria Hospital (QVH) website at
www.qvh.nhs.uk/board-of-directors/

The directors of QVH are responsible for preparing this annual 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 2019/20 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 performance achieved in 2019/20 compared to 2018/19 is shown in section 6 of the annual accounts.

In 2019/20 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 statement describing the better payment practice code, or any other policy adopted on payment of suppliers, and performance achieved.

The Trust has at all times complied with the cost allocation and charging guidance issued by HM Treasury.

Better Payment Practice code	**2019/20 Number**	**2019/20 £000**	**2018/19 Number**	**2018/19 £000**
Total non-NHS trade invoices paid	20,007	41,045	20,536	34,881
Total non-NHS trade invoices paid within target	17,817	36,510	16,989	30,487
Percentage of non-NHS trade invoices paid within target	89%	89%	83%	87%
Total NHS trade invoices paid	1,033	5,074	920	5,323
Total NHS trade invoices paid within target	754	3,945	580	3,324
Percentage of NHS trade invoices paid within target	73%	78%	63%	62%
Total NHS and non-NHS trade invoices paid	21,040	46,119	21,456	40,204
Total NHS and non-NHS trade invoices paid within target	18,571	40,455	17,569	33,811
Percentage of trade invoices paid within target	88%	88%	82%	84%

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 2019/20 QVH meet 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.

Fees and charges
During 2019/20, the Trust incurred consultancy costs of £214,000. This was largely for external resource to support the outpatient productivity initiative and external resource to support the coding of activity.

NHS Improvement's well-led framework
QVH has had regard to NHS Improvement's well-led framework in considering the organisation's performance, internal control, board assurance framework and the governance of quality. More detail can be found in section 2.2 of this report; the analysis and explanation of development and performance also includes information on the Trust's external review of governance.

Patient care
A detailed account of how the Trust delivers and monitors the quality of patient care will

be included in the quality report published later this year, which includes performance against key healthcare targets, arrangements for monitoring national improvements in the quality of healthcare, and patient experience.

Stakeholder relations

As described earlier in this report, QVH operates a networked model from its 'hub' hospital site in East Grinstead, West Sussex. Reconstructive surgery services (a mix of planned surgery and trauma referrals) are provided by QVH in 'spoke' facilities at other major hospital sites across Kent, Surrey and Sussex, and QVH also receives referrals from these hospitals. In addition, QVH provides community-based clinical services into which GPs can refer, based on a range of sites across Kent and Sussex.

We work closely with Brighton and Sussex University Hospitals NHS Trust to support the delivery of our specialised services. We have a number of joint medical posts and QVH provides plastic surgery support to the major trauma centre in Brighton. Western Sussex Hospitals NHS Foundation Trust is rated 'outstanding' by the Care Quality Commission and currently provides leadership for Brighton and Sussex University Hospitals on a management contract. QVH is working with these hospital trusts to look at whether formalising our partnership working as a hospital group would benefit our patients, our staff and the wider NHS. At the time of writing no decisions have been made.

We actively seek insights from patients, healthcare professionals, the public, and key stakeholders on the quality and effectiveness of our services to help inform service change and decisions. Our public and patient involvement activities encompass a broad range of approaches to enabling people to voice their views, needs and wishes, and to contribute to plans, proposals and decisions about services. This includes a number of mechanisms for formally monitoring and reporting what patients say about their experience of QVH.

- QVH participates in all relevant national patient surveys. While we receive consistently high response rates and predominantly positive feedback, we are not complacent and use this insight to inform further improvements.
- Patient advice and liaison service (PALS) contacts and complaints. We receive around 25 PALS contacts and 5 complaints per month and these are reviewed with a high level of detail at the quality and governance sub-committee of the board, and reported in summary to the board.
- Patient story at public board meetings. This is often a patient attending in person to describe their experience of care and plays an important role in setting the tone of board meetings, ensuring we have patients at the centre of our thinking. It also provides real insight into our services from a patient's perspective.
- Ratings sites. We monitor and respond to Care Opinion and the NHS website, online sites inviting patient feedback. This also forms part of our reporting to the quality and governance committee and the board.
- QVH social media. We receive a considerable volume of patient feedback through the QVH Facebook and Twitter accounts. As well as using these to pass on thanks to staff, patients do sometimes use them to raise concerns which are passed to the patient experience manager immediately.
- Themes raised through all these routes are triangulated with national and local surveys and staff feedback to ensure we act on issues raised by patients.

The QVH patient experience group includes patient representatives, a learning disability representative, public governors and Healthwatch. The group has been involved in work such as improving our food and in a programme reviewing the outpatient experience.

In spring 2019 we worked with advice and support from the clinical commissioning group engagement team to seek the views of children and their parents/guardians who had recently used the QVH paediatric inpatient burns service. The interviews were designed

to explore views on the current service and what should be taken into account in any potential relocation of the service. The feedback was considered in the decision to implement a temporary divert of paediatric burns inpatients to other hospitals and shared with the receiving hospitals. It will also be used to inform the business case for longer-term service change in this specialism, ensuring that we work to protect what users most value about the service and seeking further improvements.

Work to improve burns services in Kent, Surrey and Sussex, and plans for the temporary divert for inpatient paediatric burns patients, were reviewed by the chairs of health overview and scrutiny committees from across Kent, Surrey, Sussex at their meeting in July 2019.

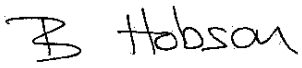
In October 2018 we began a programme of engagement with our neighbours, staff and other stakeholders on our estates strategy, including events where we were able to show people our plans using a model of the hospital site. We have continued to engage our stakeholders around our vision for the future of our site in East Grinstead, working with planners and architects to develop plans for the sale of some unused land belonging to the hospital which could help raise funds for the hospital as well as providing new homes.

Steve Jenkin
Chief Executive and Accounting Officer
22 June 2020

3.2 Remuneration report

Annual statement on remuneration
In 2019/20 very senior management (VSM) pay guidance from NHS Improvement was delayed until January 2020. The correspondence made clear that this guidance was for both foundation and non-foundation trusts and no action could be taken on VSM pay until it was released; the QVH nomination and remuneration committee therefore postponed scheduled meetings earlier in the year.

Following receipt of guidance, a meeting of the committee took place and the salaries of the executive directors and chief executive were increased, pro-rata, in line with NHS Improvement guidance. The committee remained assured that the Trust was in step with comparable benchmarked trusts at the median level.



Beryl Hobson
Chair of the nomination and remuneration committee
22 June 2020

Very senior managers' remuneration policy
The salary and pension entitlements of very senior managers are set out in the section below showing information subject to audit. 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. All junior doctors at QVH are now on the new contract.

QVH does not intend to implement separate arrangements for performance related pay or bonuses unless further guidance from NHS England and NHS Improvement is issued.

All very senior managers' pay arrangements are subject to approval by the nomination and remuneration sub-committee of the board of directors. In terms of new appointments, the committee is cognisant of the Trust's data in relation to gender pay gap, workforce race equality standard and workforce disability equality standard which are summarised in the Trust annual equalities and diversity report, and when vacancies have arisen have proactively encouraged applications from all communities. The executive management team has remained stable throughout 2019/20, with only the medical director reaching the end of a three year tenure.

In relation to agreeing and reviewing very senior managers (VSM) pay, the committee refers to the existing guidance on pay for very senior managers in NHS trusts and foundation trusts published by NHS Improvement.

The members of QVH nomination and remuneration committee agreed simple principles in relation to setting, agreeing and reviewing VSM pay. For new director appointments, the director of workforce will review benchmarking data as well as seeking market intelligence on the salaries being offered to directors which will also take account of supply and demand at that time. The review of existing VSM pay will continue to take place once a year, the timing is dependent on information being published by NHSI/E and the committee will also take account of:

- The outcome of annual appraisal conducted by the chief executive (or chair in the case of the chief executive's pay)
- The level of the national pay award for the workforce on Agenda for Change

- Any extenuating circumstances/market conditions highlighted by the chief executive
- Updated benchmarking information and guidance.

The effectiveness and performance of very senior managers is determined through performance appraisal, linked to the Trust's five key strategic objectives from which a set of individual objectives are developed. These are reviewed through the year by the chief executive (or chair in the case of the chief executive) to determine progress and achievement. The Trust's key strategic objectives also underpin the board assurance framework which is reviewed at every board meeting and every committee to the board.

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 through an agency 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.

During 2019/20 the executive management team has overseen robust pay and vacancy controls for all roles through weekly meetings.

Remuneration tables
The salary and pension entitlements of very senior managers and of non-executive directors are set out in the tables below showing information subject to audit. During the year no senior manager was paid more than £150,000.

Service contracts obligations
There are no service contract obligations 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 very senior managers whose remuneration is set by the nomination and remuneration committee. Where a very senior manager receives payment for loss of office, this is determined by their notice period. For all executive directors the notice period is three months and the chief executive six 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 very senior managers and directors. Pay at senior levels was reviewed in 2019/20 in line with clear guidance from NHSI/E and the nomination and remuneration committee approved the recommended fixed sum increase (pro rata) to members of the executive team and chief executive. This took into account NHS Improvement benchmarking of very senior management pay across the UK.

Annual report on remuneration

Information not subject to audit

Service contracts

Name	Position	Start date	Term	Notice period
Steve Jenkin	Chief executive	14 November 2016	Permanent	6 months
Geraldine Opreshko	Director of workforce and organisational development	26 July 2017	Permanent	3 months
Abigail Jago	Director of operations	8 May 2018	Permanent	3 months
Keith Altman	Medical director	1 October 2019	Permanent	3 months
Ed Pickles	Medical director until 30 September 2019	1 October 2016	Permanent	3 months
Clare Pirie	Director of communications and corporate affairs	1 May 2017	Permanent	3 months
Jo Thomas	Director of nursing and quality	15 May 2015	Permanent	3 months
Michelle Miles Lucy Owens *	Director of finance and performance Interim director of finance and performance	1 February 2018 February 2020 – March 2020	Permanent Interim on Bank	3 months One week

* To cover a period of planned absence of Michelle Miles, director of finance and performance

Nomination and Remuneration committee

The nomination and remuneration committee meets to review and make recommendations to the board of directors on the composition, balance, skill mix, remuneration and succession planning of the board. Additionally, the committee makes recommendations on the appointment of executive directors. 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 very senior managers reporting to the chief executive.

The committee met three times in 2019/20. One was a virtual meeting to ratify the recommendations of the Local Clinical Excellence awards panel; another was to agree the appointment of the medical director when the previous incumbent came to the end of their three year term; the third meeting was to discuss the cost of living pay awards for the executive directors including 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 2019/20 by Geraldine Opreshko, director of workforce and organisational development. This was in person or by advice and guidance to the Chair.

Disclosures required by the Health and Social Care Act

Information on the remuneration of the directors and on the expenses of directors is provided in the section overleaf, setting out information subject to audit.

Governors

Information on the expenses of the governors is provided in the tables below.

01 April 2019 – 31 March 2020		
Total number of governors in office	Number of governors receiving expenses in 2019/20	Aggregate sum of expenses paid in 2019/20 (rounded to the nearest £00)
27 served for all of part of 2019/20	2	£575.20

01 April 2018 – 31 March 2019		
Total number of governors in office	Number of governors receiving expenses in 2018/19	Aggregate sum of expenses paid in 2018/19 (rounded to the nearest £00)
27 served for all of part of 2018/19	1	£500

Information subject to audit
Salary and pension entitlements of very senior managers

SALARY AND PENSION ENTITLEMENTS OF VERY SENIOR MANAGERS

A) Remuneration 2019/20

			2019/20	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20
			Salary & fees (in bands of £5k)	Benefits in kind	Annual performance-related bonuses (in bands of £5k)	Long-term performance-related bonuses (in bands of £5k)	All pension-related benefits	Other remuneration	Total
			£000s (Band of £5k)	£s (nearest £100)	£000s (Band of £5k)	£000s (Band of £5k)	£000s (Band of £2.5k)	£000s (Band of £5k)	£000s (Band of £5k)
Altman K *	Medical Director	from 1 Oct 2019	110 - 115	-	-	-	- -	-	110 - 115
Colwell V	Non-Executive Director	to 19 April 2019	0 - 5	-	-	-	- -	-	0 - 5
Dillon-Robinson P	Non-Executive Director	from 1 Oct 2019	5 - 10	-	-	-	- -	-	5 - 10
Gould K	Non-Executive Director		10 - 15	-	-	-	- -	-	10 - 15
Hobson B	Chair		40 - 45	-	-	-	- -	-	40 - 45
Jago A	Director of Operations		100 - 105	-	-	-	15.0 - 17.5	-	120 - 125
Jenkin S	Chief Executive		145 - 150	-	-	-	32.5 - 35.0	-	175 - 180
Miles M	Director of Finance and Performance		120 - 125	-	-	-	- -	-	120 - 125
Needle G	Non-Executive Director		10 - 15	-	-	-	- -	-	10 - 15
Norman K	Non-Executive Director	from 8 April 2019	10 - 15	-	-	-	- -	-	10 - 15
Opreshko G	Director of Workforce and Organisational Development		100 - 105	-	-	-	25.0 - 27.5	-	130 - 135
Owens L	Interim Director of Finance	3.2.20-26.03.20	25 - 30	-	-	-	- -	-	25 - 30
Pickles E	Medical Director	to 30 Sept 2019	70 - 75	-	-	-	- -	-	70 - 75
Pirie C	Director of Communications & Corporate Affairs		70 - 75	-	-	-	17.5 - 20.0	-	90 - 95
Thomas J	Director of Nursing		115 - 120	-	-	-	50.0 - 52.5	-	165 - 170
Thornton J	Non-Executive Director	to 30 Sept 2019	5 - 10	-	-	-	- -	-	5 - 10

*Salary attributable to the current Medical Director's clinical role is £107k

SALARY AND PENSION ENTITLEMENTS OF SENIOR MANAGERS

A) Remuneration 2018/19

			2018/19 Salary & fees (in bands of £5k) £000s (Band of £5k)			2018/19 Benefits in kind £s (nearest £100)	2018/19 Annual performance- £000s (Band of £5k)		2018/19 Long-term performance- £000s (Band of £5k)		2018/19 All pension-related benefits £000s (Band of £2.5k)			2018/19 Other remuneration £000s (Band of £5k)			2018/19 Total £000s (Band of £5k)		
Colwell V	Non-Executive Director		10	-	15	0	-		-		-		-	-			10	-	15
Gould K	Non-Executive Director		10	-	15	200	-		-		-		-	-			15	-	20
Hobson B	Chair		40	-	45	900	-		-		-		-	-			45	-	50
Jago A	Director of Operations	With effect from 08 May 2018	90	-	95	0					57.5	-	60.0				145		150
Jenkin S	Chief Executive		140	-	145	0	-		-		30.0	-	32.5	-			170	-	175
Jones S	Director of Operations	until 27 April 2018	5	-	10	0	-		-		-		-	-			5	-	10
Miles M	Director of Finance		115	-	120	0	-		-		-		-	-			115	-	120
Needle G	Non-Executive Director		10	-	15	0	-		-		-		-	-			10	-	15
Opreshko G	Director of Workfo & OD		100	-	105	0	-		-		22.5	-	25.0	-			125	-	130
Pickles E*	Medical Director		140	-	145	0	-		-		12.5	-	15.0	-			150	-	155
Pirie C	Director of Communications & Corporate Affairs		70	-	75	0	-		-		7.5	-	10.0	-			75	-	80
Thomas J	Director of Nursing		110	-	115	0	-		-					-			110	-	115
Thornton J	Non-Executive Director		10	-	15	0	-		-		-		-	-			10	-	15

*Salary attributable to medical clinical role 120-125

SALARY AND PENSION ENTITLEMENTS OF VERY SENIOR MANAGERS

B) Pension benefits

			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-Mar-20	Lump sum at age 60 related to accrued pension at 31-Mar-20	Cash equivalent transfer value at 01-April-19	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31-Mar-20
			(bands of £2,500) £'000	(bands of £2,500) £'000	(bands of £5,000) £'000	(bands of £5,000) £'000	£'000	£'000	£'000
Jago	A	Director of Operations	0-2.5	0-2.5	25-30	45-50	352	23	383
Jenkin	S	Chief Executive	2.5-5	0-2.5	5-10	0	104	50	156
Miles	M	Director of Finance and Performance*	0	0	0	0	386	0	395
Opreshko	G	Director of Workforce and Organisational Development	0-2.5	0-2.5	5-10	0	62	30	94
Pickles	E	Medical Director (to 30 Sept 2019)	0-2.5	0-2.5	40-45	90-95	710	11	738
Pirie	C	Director of Communications & Corporate Affairs	0-2.5	0-2.5	20-25	40-45	314	25	347
Thomas	J	Director of Nursing	2.5-5	7.5-10	40-45	120-125	778	83	880

* No longer an active member of the scheme and therefore not actively accruing greater benefits in this position as Director.

All taxable benefits shown in the tables above are in relation to expenses allowances that are subject to UK income tax and paid or payable to the director in respect of qualifying service.

No performance related bonus was paid in 2018/19 or 2019/20.

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.

Fair Pay Multiple

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in QVH in the financial year 2019/20 was £185k to £190k (2018/19, £140k to £145k). This was 5.9 times (2018/19, 4.8 times times) the median remuneration of the workforce, which was £32k (2018/19, £29k).

In 2019/20, 4 (2018/19, 13) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £198k to £213k (2018/19 £151k to £205k).

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

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

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

Steve Jenkin
Chief Executive and Accounting Officer
22 June 2020

3.3 Staff report

Analysis of staff costs

Analysis of average staff numbers

The table below shows the average number of staff employed by the Trust each month in 2019/20.

PERMANENTLY EMPLOYED													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average
Headcount	1,075.23	1,088.25	1,092.00	1,093.00	1,122.00	1,099.40	1,100.50	1,096.25	1,104.40	1,115.75	1,113.75	1,126.20	1,102.23
FTE	869.23	887.81	876.09	874.47	871.82	873.00	878.32	880.77	878.22	871.19	889.04	898.76	879.06
TEMPORARY STAFF-BANK, LOCUM, AGENCY													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Non-medical bank	107.26	115.03	58.75	68.30	71.91	70.09	76.73	79.61	61.09	60.15	69.43	69.98	75.69
Non-medical agency	29.74	26.45	33.66	36.41	27.50	20.06	35.29	25.12	23.57	18.87	16.65	13.83	25.60
Medical locums	3.81	5.86	1.56	0.57	0.28	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.01
Medical bank	0.00	0.00	0.00	0.00	0.00	4.73	3.15	7.11	3.42	1.38	1.38	2.23	1.95
Medical agency	2.47	6.75	1.90	1.04	1.61		5.38	3.33	3.56	1.12	0.75	0.66	2.60
Total average full time equivalent staff numbers 2019/20													985.90

Breakdown of number of male and female directors, other senior managers and employees

The table below shows the gender breakdown in the Trust.

2019/20 data						
	Chief executive	Executive directors	Non-executive directors	Other senior managers	All other employees	Total
Female	0	2	2	3	813	820
Male	1	1	3	0	252	257
Total						1077

The Trust publishes an annual gender pay gap report and associated action plan. Due to the COVD-19 pandemic publication of these reports was delayed by the NHS for the year 2019/20. Reports are published on the Trust website and on the Cabinet Office website (https://gender-pay-gap.service.gov.uk/).

Sickness absence data

In line with national guidance, the table shows the sickness absence for the calendar year January to December 2019.

2019/20 Data		
Total full time equivalent staff years available	Total days lost	Average number of days of sickness absence per full time equivalent employee
876	9,553	6.7

Detailed information can be found at https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Employee benefits and staff numbers

	Permanent	Other	2019/20 Total	2018/19 Total
	£000	£000	£000	£000
Salaries and wages	39,944	149	**40,093**	37,681
Social security costs	3,936	-	**3,936**	3,831
Apprenticeship levy	182	-	**182**	170
Employer's contributions to NHS pension scheme	6,492	-	**6,492**	4,210
Pension cost - other	14	-	**14**	11
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	-	-	**-**	-
Temporary staff	-	2,810	**2,810**	3,351
Total gross staff costs	**50,568**	**2,959**	**53,527**	**49,254**
Recoveries in respect of seconded staff	(37)	-	**(37)**	-
Total staff costs	**50,531**	**2,959**	**53,490**	**49,254**
Of which				
Costs capitalised as part of assets	175	423	**598**	373

Staff policies and actions applied during the financial year

During 2019/20, QVH continued to ensure all staff policies are systematically reviewed and updated and comply with changes in legislation, and that employment policies are in line with current good practice and ensure that applicants and employees are treated fairly and equitably. Key staff policies reviewed in 2019/20 include:

- Maintaining High Professional Standards: Conduct, Capability, Ill Health and Appeals Policies and Procedures for Medical and Dental Practitioners (May)
- Appeals Policies and Procedures for Medical and Dental Practitioners (April)
- Special Leave Policy (May)
- Study and Professional Leave Policy for Medical and Dental Staff (June)
- Unpaid Parental Leave Policy (September)
- Paternity Policy (Maternity/ Adoption Support) (September)
- Disciplinary Policy and Procedure (September)
- Medical Appraisal, Revalidation and Remediation Policy (September)
- Mandatory and Statutory Training Policy (September)
- Maternity, Adoption and Shared Parental Leave Policy (October)
- Domestic Violence Abuse Policy (Staff) (October)
- Change Management Policy (October)
- Temporary Staffing Operational Policy and Management Guidelines (November)
- Time Off in Lieu (TOIL) Guidelines (January 2020).

Other actions taken in year included:

- Launch of the Health & Safety Executive's online work-related stress indicator tool
- Two-day basic skills mediation training for 18 delegates from a cross-section of staff across the Trust.

Policies applied during the financial year for giving full and fair consideration to applications for employment made by disabled persons, having	QVH has a positive approach to applications from people with disabilities and makes adjustments where appropriate for interview and employment. The Trust is registered as a Disability Confident Employer, and the revised recruitment and selection training for managers

regards to their particular aptitudes and abilities	covers in detail the required steps for supporting disabled candidates during the recruitment process.
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 Trust continues to provide training sessions and ongoing support for managers and staff around disability, including a successful programme around mental health wellbeing. Our occupational health provider is very supportive of our disabled staff and is working with managers to ensure reasonable adjustments are made when recommended.
Policies applied during the financial year for training, career development and promotion of disabled employees	QVH works with individual staff who have disabilities, discussing their needs on a case-by-case basis. QVH is registered with the Disability Confident scheme and is committed to deliver against the NHS Employers recommended workforce disability equality standard within the next year.
Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees	During 2019/20 the chief executive continued to host regular staff briefing sessions, covering the Trust's latest quality, operational, financial and workforce performance metrics and analysis as well as plans for exploring a strategic partnership with other NHS trusts. The Team Brief cascade system, where managers pass on the detail of the briefing to their team, continued. Since its launch in 2017/18, the face to face briefing which takes place throughout the organisation has seen some improvement in take up. The chief executive writes a blog which directly encourages comment from staff and continues to receive helpful feedback. A weekly staff newsletter provides an effective method of communication. Important news and developments are reported to staff in real time by email whenever necessary. The intranet site for staff, Qnet, was further enhanced to improve navigation and appearance and also includes new pages for clinical and medical education. Members of the executive team regularly attend local team meetings for Q&A sessions. The Trust was also a pilot site for the Clever Together, Best Place to work initiative which involved staff in crowdsourcing online conversations on themes that matter to them.
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, continuous improvement of care quality, workforce challenges and so on. 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	During 2019/20 a range of initiatives were successfully continued including breakfast and afternoon tea sessions for staff with the chief executive and chair; the team brief approach described above; staff excellence awards and recognition for long service and educational achievements. There are monthly meetings of the hospital management team, with senior clinical leaders from across the Trust involved in strategy and decision making. 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. The Freedom to Speak up Principal Guardian was elected by the workforce and continues to report directly to the chief executive in this role.
Information on health and safety performance and occupational health	The Trust's health and safety group regularly receives reports highlighting any risks and how they are being addressed, with quarterly information on the support provided to staff through our occupational health and employee assistance providers. Our occupational health services have been provided by a new provider, The Robens Centre, since June 2019. Data on this is also included the workforce reports to board and committees of the board. The QVH staff physiotherapy self-referral service has continued to be successful in supporting individuals and preventing some workplace absences. Our employee assistance provider gives all staff access to a range of personal and professional support including confidential counselling and legal advice for both work related and non-work issues; stress management; advice to staff on injuries at work; access to an online well-being portal and a 24-hour employee assistance programme which provides comprehensive advice for all staff including legal advice.
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. NHS Protect training has been revised and an annual counter fraud survey undertaken. All board members received update training at a board seminar

The board of directors was provided with an annual report on workplace diversity in November 2019, with progress marked against various equality initiatives and contractual

requirements. This includes information on the gender pay gap, workforce race equality standard (WRES) and workforce disability equality standard (WDES) which are all published on the Trust's public website.

Employee policy and service developments in the Trust require an equality impact assessment to encourage reflection on potential impacts to those with protected characteristics and human rights principles. Equality impact assessment is also embedded within the business case development process and guidance is provided for managers on carrying out these assessments.

Retention and attraction challenges
During 2019/20 the Trust experienced a more positive year and reaped the benefits of a sustained attraction and retention campaign that began the year previously. We collaborated with two other NHS trusts for the overseas recruitment of nurses, including operating department practitioners. This, along with some local success, saw the Trust rolling annual turnover decrease by 5% in the year, the highest number of substantive staff in post ever and a reduction in agency usage by more than half. This was also reflected in the 2019 NHS staff survey results and ongoing staff friends and family feedback.

A key challenge in the latter part of the year particularly has been the impact, predominantly on medical and dental staff, of the pension tax issue. This affected morale as well as leading to a significant reduction in activity as staff impacted are not willing to undertake any waiting list initiatives.

The Trust will continue to promote the hospital as the best place to work. We promote the Trust through media and social media, attracting widespread positive coverage.

Workforce continues to be the single biggest challenge and risk in the NHS nationally. A draft national People Plan will seek to address many of these challenges. Our geographical location does disadvantage us with a high cost of living and supplements offered by other trusts. National concerns around the impact of Brexit on workforce and the potential impact of the pandemic on overseas recruitment are issues which we will continue to monitor closely on a Trust level too.

Off payroll engagements
Use of off-payroll arrangements is subject to authorisation by the board of directors' nomination and remuneration committee.

In the financial year 2019/20 the Trust had no off-payroll arrangements.

All off-payroll engagements as of 31 March 2020, for more than £245 per day and that last for longer than six months	
Number of existing engagements as of 31 March 2018	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 2019 and 31 March 2020, for more than £245 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 2017 and 31 March 2018	0
Of which: Number assessed as within the scope of IR35 Number assessed as not within the scope of IR35	 0 0
Number engaged directly (via PSC contracted to Trust) and are on the Trust's payroll	0
Number of engagements reassessed for the consistency/assurance purposes	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020	
Number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year	**0**
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on payroll engagements	**0**

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 2019/20 QVH did not make any compulsory redundancies or agree any contractual payments in lieu of notice.

Trade union facility time disclosures

Queen Victoria Hospital NHS Foundation Trust
Trade Union Facility Time Regulations (2017)
2019/20 Report

Table 1

Relevant union officials

What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	*Full-time equivalent employee number*
7	*5.6*

Table 2

Percentage of time spent on facility time

How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	*Number of employees*
0%	
1-50%	7
51%-99%	
100%	

Table 3

Percentage of pay bill spent on facility time

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

First Column	*Figures*
Provide the total cost of facility time	£2,104
Provide the total pay bill	£50,826,980
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.004%

Table 4

Paid trade union activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100
0%

Staff survey results

Staff engagement

Improving staff engagement, engendering a sense of belonging, commitment and enthusiasm for our work and aligning the organisation's values is the most powerful and sustainable transformation we could ask for.

The engagement of staff is key in helping the Trust meet both current and future challenges. We will involve staff wherever possible in decisions and communicate clearly with them to help maintain and improve staff morale especially through periods of uncertainty and change.

Although in earlier years the Trust had seen a decline in our workforce recommending the Trust as a place to work, the 2018 and 2019 NHS staff surveys showed a step change in this score – an improvement of 15% over two years.

The Trust remains proactive in cascading information through the face to face Team Brief, which includes a feedback mechanism, and promoting and embedding an open and transparent culture where we listen and act on suggestions and concerns raised by the workforce.

We continue to implement the action plan from the work undertaken a part of the NHS Improvement retention improvement project, which has now become business as usual.

During the summer of 2019 the Trust was one of five pilot sites across Kent, Surrey and Sussex for the Clever Together Best Place to Work crowd sourcing conversation. All staff, including those on the bank, were invited to take part and 33% of all staff participated. Collectively 119 ideas were posted on how to improve working life at QVH, with 542 comments on those ideas and 2,926 votes on those ideas and comments.

Our people and organisational development strategy clearly sets out the Trust's vision, ambitions and plans for the development of QVH through our workforce, and is based around five key workforce and organisational development goals which link with many of the themes in the 2019 staff survey:

People and organisational development goals	Staff survey themes
Engagement and Communication	Staff Engagement and Team Working
Attraction and Retention	Morale
Health and Wellbeing	Health & Wellbeing and Safe Environment (Bullying & Harassment and Violence)
Learning and Education	Quality of Appraisals
Talent and Leadership	Immediate Managers

Leadership for this work comes from the director of workforce and organisational development, and progress against these goals is reported in workforce reports to the board and key committees under the Best Place to Work banner.

NHS staff survey

The NHS staff survey is conducted annually. From 2018 the results have been grouped to give scores in themed indicators. Team working was added as an additional theme this year. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

This year we surveyed 1,009 eligible staff. Of these, 586 responded making a 58% return, an increase from 52% the year before. The 2019 benchmarking group for acute specialist trusts has 14 organisations and showed a 58% return rate overall.

	2015	2016	2017	2018	2019
Best	64.3%	69.1%	62.0%	63.2%	69.6%
Your org	49.6%	55.5%	54.9%	52.2%	58.1%
Median	49.6%	49.7%	52.8%	52.8%	58.1%
Worst	31.8%	39.2%	38.0%	40.5%	46.3%

Out of 90 questions asked in the 2019 NHS Staff Survey, 12 were significantly better, 76 had no significant difference and 2 were significantly worse than 2018.

The core questions around engagement which feed into the Staff Friends and Family test and the board reports are shown below. QVH has improved on last year's results in all areas and in particular Q21c is one of our most improved results overall.

Q	Description	2015	2016	2017	2018	2019
Q21a	Care of patients/service users is organisation's top priority	88%	81%	82%	86%	88%
Q21c	Would recommend organisation as place to w ork	76%	62%	57%	62%	72%
Q21d	If friend/relative needed treatment w ould be happy w ith standard of care provided by organisation	93%	91%	88%	91%	92%

Summary details of any local surveys and results

Staff Friends and Family Test results for QVH in 2019/20 show positive trends in the percentage of people likely or extremely likely to recommend QVH as a place to receive care/work.

Staff Friends and Family 2019/20 questions	Q1	Q2	*Q3	Q4
How likely are you to recommend Queen Victoria Hospital to friends and family if they needed care or treatment?	97.62%	97.35%	92%	95.35%
How likely are you to recommend Queen Victoria Hospital to friends and family as a place to work?	74.60%	71.73%	72%	74.71%

*Relates to 2019 NHS Staff Survey

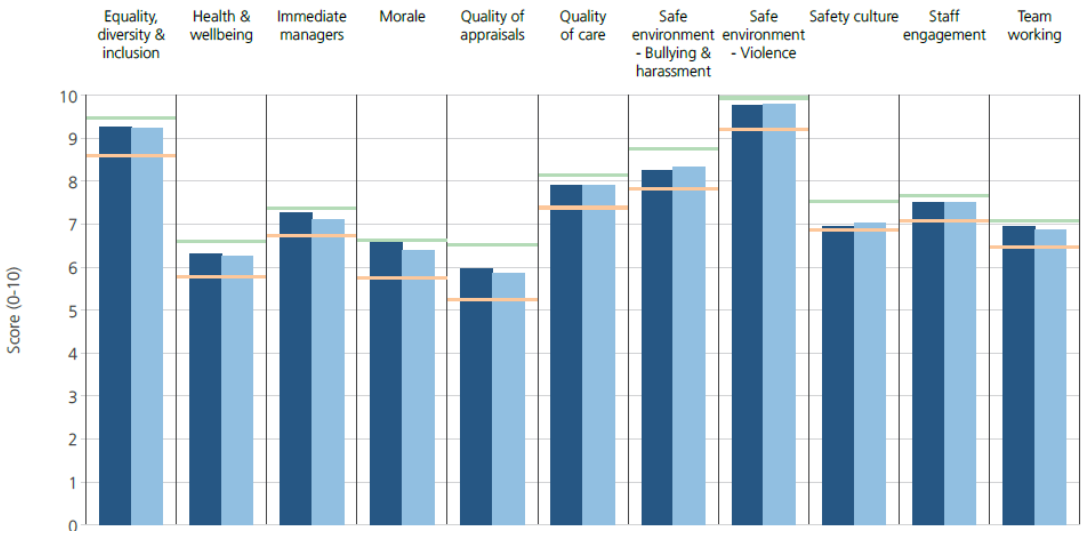
Areas of improvement

Of the 11 themes agreed for the 2019 NHS Staff Survey, QVH's results show an improvement in 9 out of 11 themes and 2 remained at the same level compared to 2018.

Theme	2018 score	2018 respondents	2019 score	2019 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.3**	486	**9.3**	573	Not significant
Health & wellbeing	**6.2**	493	**6.3**	579	Not significant
Immediate managers	**7.0**	496	**7.3**	578	Not significant
Morale	**6.2**	485	**6.6**	569	↑
Quality of appraisals	**5.7**	409	**6.0**	496	Not significant
Quality of care	**7.7**	441	**7.9**	511	Not significant
Safe environment - Bullying & harassment	**8.2**	485	**8.2**	575	Not significant
Safe environment - Violence	**9.7**	490	**9.8**	577	Not significant
Safety culture	**6.8**	488	**7.0**	573	Not significant
Staff engagement	**7.3**	496	**7.5**	580	↑
Team working	**6.7**	494	**7.0**	572	↑

Key comparisons

When compared with our comparator group of 14 specialist acute trusts, our scores are above average overall. QVH ranks above average on 5, average on 5 and slightly below average on 1.



Best	9.5	6.6	7.4	6.6	6.5	8.1	8.7	9.9	7.5	7.7	7.1
Your org	9.3	6.3	7.3	6.6	6.0	7.9	8.2	9.8	7.0	7.5	7.0
Average	9.2	6.3	7.1	6.4	5.8	7.9	8.3	9.8	7.0	7.5	6.9
Worst	8.6	5.8	6.7	5.8	5.2	7.4	7.8	9.2	6.9	7.1	6.5

When compared with the comparator group scores, QVH scores best on the themes of equality, diversity and inclusion, immediate managers, morale, quality of appraisals and team working. The worst theme is safe environment – bullying and harassment

A more in depth analysis of the 2019 staff survey question data highlights specific questions/areas where QVH has improved quite considerably over a 12 month period.

Q	Description	2018	2019
Q4f	Have adequate materials, supplies and equipment to do my w ork	54%	61%
Q4g	Enough staff at organisation to do my job properly	26%	42%
Q6a	I have realistic time pressures	20%	28%
Q6b	I have a choice in deciding how to do my w ork	55%	63%
Q6c	Relationships at w ork are unstrained	47%	54%
Q7b	Feel my role makes a difference to patients/service users	89%	93%
Q7c	Able to provide the care I aspire to	70%	78%
Q10c	Don't w ork any add unpaid hours per w eek for this organisation, over and above contracted hrs	37%	45%
Q21c	Would recommend organisation as place to w ork	62%	72%
Q23a	I don't often think about leaving this organisation	45%	54%
Q23b	I am unlikely to look for a job at a new organisation in the next 12 months	53%	60%
Q23c	I am not planning on leaving this organisation.	59%	68%

Areas for development

In addition to the specialist acute trust comparisons, further analysis identifies specific questions/areas where QVH needs to focus its actions for improvement at an organisation level:

Q	Description	2018	2019
Q12d	Last experience of physical violence reported	82%	52%
Q13d	Last experience of harassment/bullying/abuse reported	59%	49%
Q20	Had (non-mandatory) training, learning or development in the last 12 months	79%	74%
Q28b	Q28b. Disability: organisation made adequate adjustment(s) to enable me to carry out w ork	77%	73%
Q11e	Not felt pressure from manager to come to w ork w hen not feeling w ell enough	73%	70%

Physical violence has been experienced from patients (5%, which is much lower than the NHS average). The key issue is around the reporting of incidents which will be reviewed in more detail across key staff groups.

Themes summary

Based on the above findings, overall the Trust has managed to maintain largely positive survey results in comparison to the national picture in a challenging environment. There are a number of areas where QVH has made a significant improvement within the 2019 NHS Staff Survey but which must remain a focus in order to continue enhancing staff experience:

- Morale (linked to Goal 2 of the people and organisational development strategy)
- Staff engagement (linked to Goal 1 of the people and organisational development strategy)
- Team working (linked to Goal 1 of the people and organisational development strategy)

QVH will continue to assess key findings from the NHS staff survey report alongside the Picker report; Best Place to Work initiative; people and organisational development strategy; staff friends and family test; and the stay/exit interviews to ensure we effectively listen and respond to the needs of staff. Particularly relating to the 2019 NHS Staff Survey results, we need to focus on:

- Safe environment – bullying and harassment (people and organisational development strategy Goal 2)
- Equality, diversity and inclusion (people and organisational development strategy Goal 2)
- Health and wellbeing (people and organisational development strategy Goal 3)
- Safety culture (people and organisational development strategy Goal 2)

Summary of ongoing actions

Bringing together the key themes of the staff survey report, the goals outlined in the people and organisational development strategy and a full analysis of the data will enable QVH to identify specific interventions to support areas for development. This will be undertaken in collaboration with our staff and other key stakeholders. We will continue with a range of QVH interventions already underway or about to commence, including:

- Continuing the Leading the Way management development initiatives throughout 2020/21
- Develop and launch a programme of training for the administrative and clerical workforce
- Developing managers to empower them to work directly with their team on areas of improvement

- Ongoing promotion of a range of wellbeing events
- Promotion of Trust benefits
- Monitoring the mover/leavers survey to get qualitative and quantitative data to inform future attraction and retention interventions
- Continuing to deliver workshops on the importance of meaningful conversations, to include local inductions, probation meetings, appraisals (including Agenda for Change reforms) and stay/leave conversations
- Developing an appraisee workshop to raise awareness of the importance and process of appraisals at QVH
- Continuing the Best Place to Work initiative to gain insight into staff views on working for QVH
- Ongoing promotion of education, learning and development, maximising the external investment in the dental skills lab and simulation facilities.

Expenditure on consultancy

During 2019/20, the Trust incurred consultancy costs of £214,000. This was largely for external resource to support the outpatient productivity initiative and external resource to support the coding of activity.

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.

	Part of schedule A (see above)	**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 2019/20 following a review of the Trust's standing orders and standing financial instructions, and is published to the Trust's website. This suite of documents was implemented from 01 July 2019. The schedule includes a series of statements detailing the roles and responsibilities of the council of governors. Separate standing orders for the council of governors are in place. **The Trust's annual plan for 2013/14 described 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 (also published to the Trust's website) 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(s) 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. Part of this requirement is also contained within paragraph 2.22 as part of the directors' report.
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.
A register of this information is 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.				
8.	2: Disclose	Nominations Committee(s)	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	Nominations Committee(s)	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 in 2019/20				
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 deputy company secretary. This register is also included in full in the papers for meetings of the board of directors held in public.				

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 outlook for 2019/20 was presented at the annual members' meeting/AGM held on 29 July 2019, 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. The council of governors receives regular presentations by the chief executive and executive team, providing an overview of the national and local position. These lead to an informed discussion of forward plans. The governor representative model means selected governors join the board and its committees where they have the opportunity to contribute further to the forward plans. The Integrated Care Systems (formerly Sustainability and Transformation Partnerships) are an important part of our current environment. The council of governors has been updated regularly about what this means for QVH and how they can disseminate this information to members.				
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 in 2019/20				
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.

At its meeting in March 2020, the board considered an internal evaluation report which covered the collective performance of the board, the performance of its committees and the individual performance of its directors in addition to developmental opportunities throughout the year. The board was assured by this review that the Trust's governance arrangements remained fit for purpose. **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 chief executive is assessed by the chair 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. Processes for performance evaluation for directors and the chair continue to be refined on an annual basis to ensure input remains meaningful.**				
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 in 2019/20				
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 2.95
See the annual governance statement 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 the annual governance statement 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 2019/20 the Trust's internal audit function was provided by RSM Risk Assurance Services 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 2019/20 included: • **Recruitment** • **Consultant job planning** • **Referrals and waiting list management** • **Theatre utilisation** • **Financial management** • **Rostering and workforce planning** • **Estates and facilities** • **Risk management and risk culture** • **Financial systems and payroll** • **GDPR – DPS toolkit**				
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 2019/20				

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 each meeting, there is a closed session between the chair of the audit committee and committee members with the internal and external auditors.

During 2019/20:

- **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.**

Through the year end audit process, the Trust's external auditors described significant audit risks around the valuation of the land and buildings which highlights the risks due to the COVID-19 pandemic; the audit committee considered this and the Trust will undertake a further valuation exercise in 2020/21. The auditors also considered the revenue recognition for the Trust with no matters arising from this audit, and expenditure recognition with a medium recommendation raised which has been accepted by the Trust.

- **In Q3, the committee undertook a review of its effectiveness and terms of reference. Its work programme was also reviewed and updated during the last quarter of the financial year to ensure it remained relevant and meaningful.**
- **The internal auditor's opinion, based on the work performed to 31 March 2020 is that the organisation has an adequate and effective framework for risk management, governance and internal control. However further enhancements have been identified for the framework of risk management, governance and internal control to ensure it remains adequate and effective.**
- **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. The Trust participates in the national agreement of balances exercise performed at months nine and twelve. 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. The Trust also receives a material amount of other operating income for education and training.

Trusts are responsible for ensuring that the valuation of their property, plant and equipment is correct and for conducting impairment reviews that confirm the condition of these assets. As a result of the suggested accounting policies provided by NHS Improvement, 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 Trust undertook a full valuation review during 2019/20.

The valuation exercise was carried out in January 2020 with a valuation date of 31 March 2020. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust.

Valuer's report: "The outbreak of the Novel Coronavirus (COVID-19), declared by the World Health Organisation as a "Global Pandemic" on the 11th March 2020, has impacted global financial markets. Travel restrictions have been implemented by many countries. Market activity is being impacted in many sectors. As at the valuation date, we consider that we can attach less weight to previous market evidence for comparison purposes, to inform opinions of value. Indeed, the current response to COVID-19 means that we are faced with an unprecedented set of circumstances on which to base a judgement. Our valuation is therefore reported as being subject to 'material valuation uncertainty' as set out in VPS 3 and VPGA 10 of the RICS Valuation – Global Standards. Consequently, less certainty – and a higher degree of caution – should be attached to our valuation than would normally be the case. Given the unknown future impact that COVID-19 might have on the real estate market, we recommend that you keep the valuation under frequent review.

"For the avoidance of doubt, the inclusion of the 'material valuation uncertainty' declaration above does not mean that the valuation cannot be relied upon. Rather, the declaration has been included to ensure transparency of the fact that – in the current extraordinary circumstances – less certainty can be attached to the valuation than would otherwise be the case. The material uncertainty clause is to serve as a precaution and does not invalidate the valuation."

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				
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:

- **The lead governor is invited to attend all meetings of the board of directors including seminars, workshops and meeting sessions held in private. A requirement of this role is to provide feedback to governor colleagues to contribute to the council of governor's statutory duty to hold non-executive directors (NEDs) to account for the performance of the board of directors.**

- **Directors attend all meetings of the council of governors held in public. In 2019/20 council meeting agendas continued to be refined to provide more opportunities for non-executive directors to report to the council and for dialogue between NEDs and governors generally.**

- **The board invites a governor representative to attend meetings of its committees and feedback to governor colleagues. As the board committees are chaired by NEDs this facility gives more governors the opportunity to observe NEDs performing their duties as well as providing governors with wider insight into the operational activities of the Trust and corporate governance.**

- **The board of directors and council of governors have in place a document formalising principles of engagement between the council's governor representatives and the Trust's board-level structures and mechanisms. This underwent annual review at the council of governors meeting in January 2020.**

- **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.**

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 board 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. Nonetheless, it ensures it continues to meet its responsibility to engage with stakeholders through various means, including the regular scrutiny of Friends and Family Test and patient experience results. A QVH patient is invited to nearly every board meeting to describe their experience of care at the Trust. The governor representative roles continue to enable strong and direct engagement between governors and the board, especially non-executive directors.				
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 or governors should contact the deputy company secretary on 01342 414200 or hilary.saunders1@nhs.net This information is also available from the Trust's website at: www.qvh.nhs.uk/board-of-directors and www.qvh.nhs.uk/council-of-governors-2				
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 2020, the number of members within the public constituency was 7,316 and the staff constituency was 1077. **The Trust's membership strategy was reviewed by the Trust and presented to members, governors and non-executive directors at the Trust's annual membership meeting on 29 July 2019.** **Additional information regarding membership of the QVH Foundation Trust can be found online at http://www.qvh.nhs.uk/for-members/**				
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 2.22 as directors' report requirement.
A register of directors' and governors' interest is kept by the Trust and is available on request from the deputy 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 healthcare 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.
Compliant. 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 formally monthly and reports to the quality and governance 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 and quality, the head of risk and patient safety, the governance leads of clinical specialties, senior nurses 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 NHS Improvement (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
Compliant. The constitution is reviewed periodically and published to the Trust's website; The Trust's standards of business conduct and behaviour policy is regularly reviewed, revised as appropriate, approved by the Trust's audit committee and subsequently disseminated to all members of staff.				
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.
Compliant. See 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: In January 2018, the council of governors approved the recommendation of its appointments committee that the current chair be appointed for a second term from 1 April 2018, having satisfied itself that this appointment met the criteria set out in B.1.1				
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. In consultation with the council of governors, the Board appointed Gary Needle as Senior Independent Director. This appointment took effect from 1 October following the departure of John Thornton.				
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 met with the non-executive directors on alternate months throughout 2019/20				
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 2019/20				
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 2019/20 the council of governors held meetings in public in April 2019, July 2019, October 2019 and January 2020.				

38.	6: Comply or explain	Council of Governors	A.5.2	The Council of Governors should not be so large as to be unwieldy.
Compliant: 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.
Compliant. NHS/E (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.
Compliant. The chief executive, members of the executive management team and non-executive directors attend the public sessions of each quarterly meeting.				
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.
Compliant. Provision 52 of the Trust's constitution sets out provisions for disputes between the council of governors and board of directors.				
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 chair of both bodies; the roles of the director of communications and corporate affairs and the deputy company secretary as advisers 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 governor representatives to attend the board and committee meetings (see item 21 above).** **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. These roles are particularly significant as they play an important part in governors' duty to hold non-executive directors to account for the performance of the board. The roles foster closer working relationships between governors and non-executive directors and provide more opportunities for governors to see non-executive directors at work on a regular basis. As a result, governors are better able to appraise the performance of the non-executive directors and hold them to account.** **The board of directors and council of governors have agreed a document formalising principles of engagement between the council's governor representatives and the Trust's board-level structures and mechanisms. This is reviewed on an annual basis.**				
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 2019/20. 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				
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(s)	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. The board of directors' nomination committee is responsible for the identification and nomination of executive directors and the council of governors' appointments committee is responsible for identification and nomination of non-executive directors.				
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.
Compliant. The Trust's declaration of interests pro-forma for directors and governors also incorporates a fit and proper persons declaration. Declarations are made by all directors and governors accordingly with each submitting a self-assessment against the categories of person prevented from holding office. These declarations are updated on an annual basis.				
49.	6: Comply or explain	Nomination Committee(s)	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				
50.	6: Comply or explain	Nomination Committee(s)	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(s)/ 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.
Compliant. See 47 above. Part of the remit of the council of governors' appointments committee is to oversee the appointment processes for the chair and non-executive directors, making recommendations in this regard to the council of governors.				

52.	6: Comply or explain	Nomination Committee(s)	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. See 47 above				
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 2018, a skills audit of existing non-executive directors was undertaken by the chair to map skills to the Trust's key strategic objectives and identify gaps. Results of this audit were used to develop and agree the candidate brief in preparation for the recruitment of two new non-executive directors in 2019/20.				
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.
Compliant. See 51 above				
55.	6: Comply or explain	Nomination Committee(s)	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 in 2019/20				

57.	6: Comply or explain	Board/Council of Governors	B.5.1	The Board and the 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, reports from the Chair and Chief Executive 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.** **Governor representatives to the board and its committees also 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				
59.	6: Comply or explain	Board	B.5.3	The Board should ensure that directors, especially non-executive directors, have access to the 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.
Compliant. 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 non-executive directors, executive 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. The board of directors meet every other month for a seminar which gives a greater focus on strategy development and opportunities for board development. The board development programme has been shaped 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 workforce and organisational development and the director of communications and corporate affairs. At its meeting in March 2020 the board considered the approach taken to date, and discussed priorities for board development in the coming year.				
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.
Compliant. The collective performance of the council is periodically reviewed every three years. The next review is scheduled for 2021. **Communication with members and the public is provided through a bi-annual newsletter, QVH News, and through 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.
Compliant. 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 in 2019/20				
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 2.16
Compliant. See section 2.1				
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 board sets out clearly its financial quality and operating objectives for the Trust through board papers, published to the website. These include both quantitative and qualitative information on the Trust's business and operation. Clinical outcome data is also included in the annual quality account which will be published later this year.				

68.	6: Comply or explain	Board	C.1.4	a) The Board of Directors must notify NHSI/E 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, healthcare delivery performance or reputation and standing of the NHS foundation trust. b) The Board of Directors must notify NHSI/E 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, healthcare 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.				

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.
Compliant.				
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 NHSI/E informing it of the reasons behind the decision.
Not applicable in 2019/20				
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.
Compliant. In 2019/20, RSM UK 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.** **The role of the freedom to speak up guardian is specifically aimed at staff, and provides confidential advice and support in relation to concerns about patient safety. The role reports directly to the chief executive and the freedom to speak up guardian attends the board of directors meetings regularly throughout the year.**				
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. The council of governors' appointments committee undertakes an annual review ensuring that QVH remuneration reflects the time commitment and responsibilities of the roles and the need to attract, retain and motivate non-executive directors with the skills and experience to lead the Trust successfully.				
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 in 2019/20				
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.
Compliant. Following publication of the remuneration survey by NHS Providers, the appointments' committee reviewed the remuneration and terms and conditions of the chair and non-executive directors, and made recommendations in this regard to the council of governors at its public meeting on 29 July 2019.				
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.

Compliant				
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.
Compliant. Responsibility for ensuring that the views of governors and members are communicated to the board as a whole is shared between the chair, the director of communications and corporate affairs and the lead governor.				
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: The board of directors recognises that co-operation and collaboration is key to the sustainability of the organisation. Engagement with stakeholders in our local community and in the NHS is strong, with QVH well represented in all key NHS forums. **QVH maintains collaborative and productive relationships with representatives of third parties and over the last year has considered and continued to develop relationships including.** • **Western Sussex Hospitals NHS Foundation Trust and Brighton and Sussex University Hospitals NHS Trust, with specific partnership work on clinical pathways** • **Surrey and Sussex Cancer Alliance; Kent and Medway Cancer Alliance** • **The Sussex Health and Care Partnership (formerly Sussex and East Surrey STP), with executive directors and the Trust chair regularly participating in all of the associated working groups and meetings** • **The Kent and Medway STP, with links made at chief executive level and representation on QVH partnership working board** • **NHS trusts which host QVH 'spoke' services across the South East region**				
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.
Compliant. See row 81.				

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3.5 NHS Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability (well-led).

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation
NHS Improvement has placed the Trust in segment 2, the second highest category and QVH has not been subject to any enforcement actions.

This segmentation information is the Trust's position as at 1 June 2020. Up to date segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources
The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust shown above may not be the same as the overall finance score. The table below details the use of resources score in 2018/19.

Area	Metric	2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4
	Capital service capacity	4	4	4	4
Financial sustainability	Liquidity	2	1	2	4
Financial efficiency	Income and expenditure margin	4	4	4	4
	Distance from financial plan	4	1	4	4
Financial controls	Agency spend	3	3	3	3
Overall scoring		**3**	**3**	**3**	**4**

The Trust's overall year to date score is 4 for the year; the lowest score possible. A score of 3 was achieved for agency spend due to a reduction seen at the end of the financial year. The other metric measures scored 4 due to the adverse financial performance in year as the Trust slipped into deficit resulting in a shortfall in capital service capacity, a material distance from planned control total and a negative income and expenditure account margin.

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 NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions, which require Queen Victoria Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. 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, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the proper use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, 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* (and the *Department of Health and Social Care Group Accounting 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
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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 them 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.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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

Steve Jenkin
Chief Executive and Accounting Officer
22 June 2020

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 2020 and up to the date of approval of the annual report and accounts.

Capacity to handle risk
The board views risk management as a corporate responsibility, in line with the NHS Improvement 2017 Well Led Framework which requires the board to have effective systems and processes in place to mitigate and manage risk. The degree and rigour of oversight the board has over the Trust's capacity to handle risk is apparent at the public and private boards, committees of the board meetings and board seminars.

During 2019/20, the board undertook certified cyber security training using an external facilitator and the board also refreshed the Trust's risk appetite statement to reflect changes and new opportunities. This details the current risk profile of the organisation, the level of risk to which it is currently exposed and states how much risk the Trust is prepared to accept to achieve the organisation's key strategic objectives.

The Trust's risk management training programme has been reviewed and all Trust staff attend this mandatory session. A small number of staff have been trained to undertake serious incident investigations, supported by the head of risk and patient safety, which include identification of future risk and actions to minimise these risks.

The director of nursing and quality is the Trust's lead for risk, supported by the head of risk and patient safety and the head of quality and compliance. The Trust's quality and governance committee and finance and performance committee are chaired by non-executive directors, and have delegated authority from the board to review and assess the level of assurance and ensure that effective systems and processes are in place for optimum risk management. The clinical governance group is responsible for the management and monitoring of clinical risk management in the organisation and reports into the quality and governance committee. At every public board meeting there is scrutiny of the board assurance framework, the corporate risk register and detailed director reports which contain key quality and safety, operational, financial and organisational details, exception reporting and a focus on safe staffing levels. There are also reports from the chairs of the committees of the board to update on the level of assurance the committees have about quality, safety, clinical effectiveness, patient experience, operational delivery and finance.

The non-executive directors are held to account by the council of governors and the chair of the quality and governance committee presents an assurance report to each council of governors meeting as well as taking questions from governors. The governor representative of the quality and safety committee also addresses the council of governors regarding the level of assurance received.

The Trust learns from incidents internally and externally, reviewing national publications and investigations to identify relevant recommendations and learning to be shared throughout the Trust. This is achieved by utilising the clinical governance system to support the dissemination of key issues to Trust staff including the board, clinical governance group and joint hospital governance meeting. This learning is also shared

externally with our commissioners and regulators for additional scrutiny and assurance. All serious incident investigations are reviewed by the quality and governance committee and action plans are reviewed at the clinical governance group one year after the incident, for assurance that the actions completed are fully embedded in practice.

The risk and control framework

The current Trust risk management strategy covers the four year period to December 2020. The strategy outlines the framework within the Trust's governance structure and the requirements for individuals and teams to comply with key regulatory instructions and legislation, to manage risk effectively and contribute to achieving the Trust's key strategic objectives. Assurance regarding the effectiveness of this strategy is presented at the quality and governance committee. The Trust has commenced aligning the 2019 NHS Patient Safety Strategy with Trust strategy and clinical governance arrangements.

The Trust's risk management and incident reporting policy is published on the Trust intranet. The policy provides an outline of the risk processes and the ways in which a risk should be assessed, actioned and escalated. Incidents can be logged directly by the individual on the Trust reporting system or via their line manager. There is also provision for staff to raise a risk confidentially or anonymously to the director of nursing using an anonymous 'Tell Jo' email account, contacting the Trust's freedom to speak up guardian, or using the Trust's whistleblowing process.

In December 2019, an internal audit of risk management and risk culture was undertaken. The review considered two distinct areas the control framework of the centralised risk management function and the culture and behaviours of the organisation with regards to risk. Substantial assurance was achieved.

Once a potential risk is identified, the individual or team are supported by the risk team in a wider triangulation of information such as previous incidents, audits, external reviews, complaints and quality metrics to determine if this is an actual risk. If this is the case the risk is scored and appropriate actions and mitigations identified and the risk is added to department (local) or corporate risk register. If a risk score is 12 or more the risk is added to the corporate risk register. The risk registers are all reviewed monthly; the departmental risk registers at governance and business meetings and the corporate risk register by the executive management team and the quality and governance committee.

A range of data and risks are managed via the Trust risk management software package, these include incidents, complaints, claims, Care Quality Commission 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 overseen by the risk team, and the risk and incident information is shared with the business units each month forming part of the governance and risk management process. There is an escalation process for serious concerns to be escalated directly to the head of risk and patient safety, the director of nursing or medical director if required.

Staff are actively encouraged to report incidents and near misses to identify potential risks and take action to prevent these. Learning from incidents is integral to the risk process and is shared at a variety of forums and groups including the clinical governance group, quality and governance committee, staff newsletter, the cascade team briefing and the joint hospital governance group. During 2019/20 the Trust undertook significant work in critical care to reduce risk and develop a clinically led safety culture which has provided assurance to the board and was noted by the CQC in the 2019 inspection.

Within the board assurance framework there are three significant risks to the Trust's key strategic objectives. These risks are reflected in the corporate risk register. Two of these risks, 18 week referral and workforce, have reducing risk scores following effective mitigation and actions; the third, financial sustainability, remains at the same level.

Mitigating actions for managing the national 18 week referral to treatment target included the Trust inviting the NHS Improvement intensive support team to work for a second time with the Trust and redesign of pathways and developments of Standard Operating Procedures. The Trust worked transparently with commissioners and regulators as part of a whole system response to put in place a referral to treatment recovery plan which included improved waiting list reporting, a comprehensive programme of validation, a revised access policy and associated processes and provision of additional capacity so that patients could be treated as quickly as possible.

Mitigating actions for workforce have included a range of 'Best Place to Work' initiatives for staff and prospective employees. These included enhanced bank pay and a reward scheme for introducing a qualified practitioner to the Trust; innovative campaigns to attract applicants to apply for posts; investment in education and development to support existing staff; introduction of a people and organisational development strategy; and successful international recruitment in partnership with an experienced NHS provider trust partner.

Mitigating actions for financial sustainability include revised forecast deficit; review of activity plan and contract management framework; monthly performance management from NHS Improvement; additional internal performance review of the clinical and non-clinical services with a requirement from each to identify and agree cost improvements; and cost reductions; review of service lines. The detail of this is in the finance performance section. In addition, the Trust is leading work with local health economy partners and regulators to secure longer term financial sustainability, possibly through a formal partnership with other trusts.

As detailed previously under enhanced quality governance, the responsibilities and accountabilities of the board members and committees of the board are well defined within the governance structure. The Trust monitors compliance with its NHS foundation trust license condition 4 by several means, including:

- The public board meetings are held bimonthly. There are detailed reports which include all key national performance measures on quality, operational performance, finance and workforce. There is opportunity for robust challenge and debate about these reports and the way in which the directors work collaboratively in order to meet the Trust's key strategic objectives and provide leadership and oversight of the systems in place for care provision and service delivery. In addition to this governance process, the non-executive chair of each board committee presents a report to the board about the level of assurance and key items for approval or discussion. All actions are monitored via a board action log.
- The quality and governance committee and the finance and performance committee are sub committees of the board chaired by non-executive directors and receive detailed reports on quality, operational performance, finance and human resources and there is an opportunity for scrutiny and challenge by the membership. Both committees monitor completion of actions via a committee action log.
- 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 and requires evidence that effective systems and processes are in place to mitigate and manage risk.
- The board assurance framework and corporate risk register are discussed at every public board meeting.
- Timely response to NHS Improvement information and monitoring requests and executive management team attendance at the quarterly NHS Improvement performance reviews.
- Regular provider engagement meetings with the Care Quality Commission to ensure compliance with regulatory standards and compassionate care.

The governance of data security and priority work in this area is described under information governance below.

Equality impact assessments are integrated into core business. Each new or revised policy requires an equality impact assessment to be completed to ensure we meet legislative requirements and are not discriminating against protected characteristic groups. The equality impact assessment is completed by the manager writing the policy and signed off by their line manager prior to approval by the relevant ratifying committee.

Public stakeholders are involved in managing risk; this is 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 quality and governance committee and from the governor representative to the quality and governance committee.

The effectiveness of emergency planning, response and resilience (EPRR) and business continuity systems are assured through a number of mechanisms including table top exercises and lockdown drills, partnership working with commissioners and NHS England and peer review by the Local Health Resilience Partnership. The Trust has carried out the required national self-assessment which has been reported to the board and detailed improvement in compliance. There are 55 core standards applicable to QVH and we were fully

compliant in 48 of these; six standards are rated as partial compliance; and one standard is rated as non-compliant. The Trust undertook an effective table top exercise reviewing Brexit preparations. More recently the Trust has responded to the COVID-19 pandemic, working with national incident response teams and Public Health England putting in place all necessary measures.

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months as required by the *Managing Conflicts of Interest in the NHS* guidance.

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 Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its 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
During 2019/20 the Trust's financial position deteriorated in the context of increasing spend on pay and non-pay, and a reduction from plan in both activity levels and the complexity of the activity undertaken.

Concern about pensions tax meant some of our most senior staff did not deliver their usual extra clinical sessions which would have increased activity, and some significant changes in tariffs also affected income. Given the small size of the organisation, changes in tariff, workforce costs and a change in number and type of patients we see, can disproportionately affect our ability to meet our financial plans.

The Trust is forecasting a deficit in 2020/21, with a need for cash support from the Department of Health and Social Care; the material uncertainties associated with the Trust's future financial position are set out in note 1.1 to the accounts.

The value for money opinion from the Trust's auditors is an 'except for' opinion, as the Trust achieved economy, efficiency and effectiveness except in respect of financial sustainability. This is consistent with the prior year.

The Board Assurance Framework, discussed at every meeting of the board, continues to recognise the long term financial sustainability of the Trust as a key risk. The Trust works to ensure economy, efficiency and effectiveness in a number of ways including robust planning, application of controls, performance monitoring and independent reviews.

The financial plan for 2019/20 was approved by the board and submitted to NHS Improvement as required. As in year financial performance deteriorated, performance against the plan and remedial actions were examined at executive-led performance reviews and at an executive management meeting for oversight and scrutiny. Reports including forecast projections, performance indicators and supporting narrative were presented at a monthly finance and performance committee and bi-monthly to the Trust board. The organisation took steps in year to address the deteriorating financial performance as well as to ensure regulators were aware of forecast year-end position.

The Trust's resources are managed within the framework of its primary governing documents, policies and processes, including:

- Standing orders, standing financial instructions, scheme of delegation and reservation of powers to the board;
- Robust expenditure controls and
- Effective procurement procedures

The Trust board performs an important role in ensuring the economic, efficient and effective use of resources, and maintaining a robust system of internal control, and is supported in that purpose by the audit committee, internal and external audit and regulatory/advisory bodies. The Trust has an annual programme of internal audit and works closely with the internal audit provider to gain additional assurance on Trust processes. The audit committee monitors progress against the programme and implementation of recommendations identified and agreed as part of the audit fieldwork.

The finance and performance committee receives monthly updates on programme performance whilst the quality and governance committee reviews plans to ensure there is no negative impact upon the quality of service provision and/or outcomes.

Information governance
Responsibility for the information governance agenda is delegated from the chief executive to the director of finance as senior information risk owner (SIRO), and the Caldicott guardian who is the director of nursing and quality, as well as the Trust data protection officer who is the information governance lead. The SIRO is responsible for ensuring that information risk management processes are in place and are operating effectively. The Caldicott guardian is responsible for ensuring the confidentiality of patient information and appropriate information sharing.

The information governance group 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, with 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 information governance group is to oversee the Trust's annual data security and protection toolkit assessment. The toolkit is an online self-assessment tool that allows organisations to measure their performance against the national data guardian's 10 data security standards. All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly.

During 2019/20, priority has been given to cyber security and in particular addressing any threats to our systems, processes and data.

Data security risks continue to be managed and controlled via the risk management system, incorporated into the risk register and reviewed by the information governance group.

In 2019/20, no recorded data security incidents were assessed to have caused significant risk to the rights and freedoms of individual(s) and therefore reportable to regulatory authorities.

Data quality and governance
The Trust uses a range of tools and processes to bring together the correct, complete and valid data required to support sound decision making.

Previous data quality challenges have been addressed during 2019/20 through the use of an integrated data warehouse, supported by regular studies of data flows and processes and routine independent audits. New reporting structures have allowed greater automation, reducing the risk of human error and allowing experienced staff to address more complex data quality issues.

Working with other NHS partners, the Trust has established new reports and systems integrating new datasets and increasing the level of reliable intelligence that can be extracted from the data.

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 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
- An extensive programme of clinical audits assesses patient experience and measures the effectiveness of treatment provided, with action taken where indicated, to ensure high quality care with re-audit where necessary.
- The head of internal audit opinion has stated that the organisation has an adequate and effective framework for risk management, governance and internal control, recommending further enhancements which will be implemented by the Trust to ensure risk management, governance and internal control remain adequate and effective
- The quality and governance committee reviews feedback from external assessments on quality of service, including NHS Improvement, Healthwatch, Care Quality Commission, NHS Resolution 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.

Steve Jenkin
Chief Executive
22 June 2020

Independent auditor's report

to the Council of Governors of Queen Victoria Hospital NHS Foundation Trust

. REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of Queen Victoria Hospital NHS Foundation Trust ("the Trust") for the year ended 31 March 2020 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion:

— the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2020 and of its income and expenditure for the year then ended; and

— the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2019/20 and the Department of Health and Social Care Group Accounting Manual 2019/20.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Overview	
Materiality: financial statements as a whole	£1.4m (2018/19: £1.5m) 2% (2018/19: 2%) of revenue

Risks of material misstatement		vs 2018/19
Recurring risks	Revenue recognition	◀▶
	Management override of control	◀▶
	Valuation of land and buildings	▲
	Expenditure recognition	◀▶

2. Material uncertainty related to going concern

	The risk	Our response
We draw attention to note 1.1 of the financial statements which indicate that the Trust incurred a £9.2 million deficit in 2019/20 and that the Trust's cash flows for the 12 month period from the data of approval of the accounts are dependent on the acceptance and delivery of financial recovery plans and continued financial support from the Department of Health and Social Care. These events and conditions, along with the other matters explained in note 1.1, constitute a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.	**Disclosure quality** The financial statements explain how the Board has formed a judgement that it is appropriate to adopt the going concern basis of preparation for the Trust. That judgement is based on an evaluation of the inherent risks to the Trust's business model, including the impact of Covid-19, and how those risks might affect the Trust's financial resources or ability to continue operations over a period of at least a year from the date of approval of the financial statements. The risk for our audit is whether or not those risks are such that they amount to a material uncertainty that may cast significant doubt about the ability to continue as a going concern. If so, that fact is required to be disclosed (as has been done) and, along with a description of the circumstances, is a key financial statement disclosure.	Our procedures included: — Review of the Trust's financial performance in 2019/20 including its achievement of planned CIPs in the year and its underlying run rate; — Review of the Trust's 2020/21 financial plan and the level of planned savings required, in light of historic cost improvements achieved, and the projected run rate in 2020/21; — Given the impact of Covid-19, operational planning process and contracting round has been suspended for 2020/21 and block funding has been put in place with no indication from NHSE/I on the contracting arrangements for the rest of 2020/21. The guaranteed block income is in line with the commissioner income included in the draft operating plan for 2020/21 and as such there is a prediction this will result in a break-even position by M7; — Held discussions with Management regarding the communications with NHS Improvement in relation to the cash support required during 2020/21 and for the 12 months following the approval of the accounts, and reviewed the Trust's cash flow forecasts for 2020/21; — Considered the wider strategic focus and direction of the organisation, including considering the views of NHS Improvement in the assessment; and — Assessed the disclosures made in the Trust's accounts and annual report regarding its going concern status.

3. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In arriving at our audit opinion above, the key audit matters, in decreasing order of audit significance, were as follows (unchanged from 2018/19):

	The risk	Our response
Valuation of property, plant and equipment (£42.8 million; 2018/19: £42.5 million) *Refer to page 51 (Audit Committee Report), pages 96 -98 (accounting policy) and page 115 (financial disclosures)*	**Subjective valuation** Land and buildings are required to be held at fair value. The Trust's main land and buildings relate to the site at Queen Victoria Hospital, East Grinstead. The Trust undertook a full revaluation of its estate as at 31 March 2020. As explained in note 1.5 the Trust's valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by Covid-19, with the result that at the valuation date, the valuer considers that they could attach less weight to previous market evidence for comparison purposes to inform opinions of value. This has in particular impacted the assessment of land values and build costs and has increased the level of risk in relation to the valuation this year. Land and buildings are required to be maintained at up to date estimates of fair value. The Trust's entire site is considered to be specialised for the purposes of the revaluation, given that the less specialised office and ancillary buildings are so integral to the functioning of the site as a whole that they can be considered inseparable from the specialised healthcare buildings. For specialised assets where no market value is readily ascertainable, the depreciated replacement cost (DRC) of a modern equivalent asset (MEA) that has the same service potential as the existing property is taken to be the value. There is significant judgment involved in determining the appropriate basis for each asset according to the degree of specialisation, as well as over the assumptions made in arriving at the valuation and the condition of the asset. In particular, the MEA 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. The Trust currently bases its valuation on an alternative site. Valuations are inherently judgmental, as is the assessment of impairment, therefore our work focused on whether the valuer's methodology, assumptions and underlying data, are appropriate and correctly applied. The effect of these matters is that, as part of our risk assessment, we determined that the valuation of land and buildings has a high degree of estimation uncertainty, with a potential range of reasonable outcomes greater than our materiality for the financial statements as a whole.	Our procedures included: — **Assess valuer's credentials:** We assessed the competence, capability, objectivity and independence of the Trust's external valuer (Gerald Eve) and considered the terms of engagement of, and instructions issued to, the valuer for consistency with the requirements of the Department of Health Group Accounting Manual 2019/20; — **Independent specialist review**: We engaged a valuation specialist to review the methodology and assumptions used by Gerald Eve and to confirm it is in line with RICS and industry practice. We reviewed the impact of material uncertainties over the valuation due to the impact of Covid-19; — **Data comparisons:** We reconciled the information supplied to the external valuer to the Fixed Asset Register to confirm its completeness and accuracy; — **Impairment:** We assessed the need for impairment across the Trust's wider asset base that falls outside of the full revaluation and confirmed there is no impairment requirement for 2019/20; — **Test of detail:** We considered significant movements in the land and buildings balances, including additions and reclassifications, reconciling back to third party notifications; and — **Assessing transparency:** We considered the adequacy of the disclosures about the key judgements and degree of estimation involved in arriving at the full valuation and the related sensitivities with reference to the Group Accounting Manual 2019/20. In particular we considered the impact of uncertainties relating to the UK's exit from the EU and the Covid-19 pandemic upon property valuations in evaluating the revaluation and related disclosures including the adequacy of the disclosure of the material valuation uncertainty.

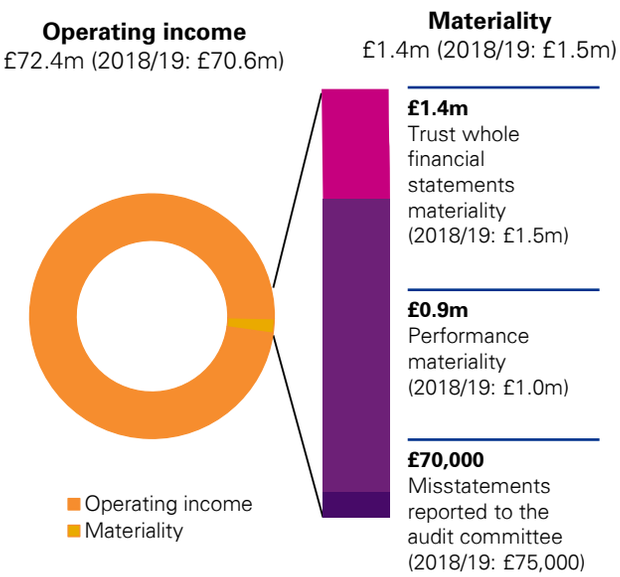
3. Key audit matters: our assessment of risks of material misstatement (continued)

	The risk	Our response
Recognition of NHS and non-NHS revenue £72.4 million (2018/19: £70.6 million) *Refer to page 51 (Audit Committee Report), pages 94-95 (accounting policy) and pages 109-110 (financial disclosures)*	**Effect of irregularities** Professional standards require us to make a rebuttable presumption that fraud risk from revenue recognition is a significant. We recognise that incentives in the NHS differ to those in the private sector driving the requirement to make a rebuttable presumption that this is a significant risk. NHS incentives include the requirement to meet regulatory and financial covenants, rather than broader share based management concerns. In 2019/20 the Trust reported total income of £72.4m (2018/19, £70.6m). £65.7m (2018/19: £62.6m) relates to contracts with NHS commissioners. This represents 91% of total income (2018/19: 89%). The remaining £6.7m (2018/19: £8.0m) was from contracts with other NHS bodies, local authorities and other non-NHS organisations. The Trust participates in the Agreement of Balances (AoB) exercise which is mandated by the Department of Health and Social Care (the Department), covering the English NHS, for the purpose of ensuring that intra-NHS balances are eliminated on consolidation of the Department's resource account. Mismatches in income and expenditure, and receivables and payables are recognised by the Trust and its counterparties to be resolved. Where mismatches cannot be resolved they can be reclassified as formal disputes. The Trust was not eligible to receive Provider Sustainability Fund funding (PSF) in 2019/20 based on not meeting the control total set by NHS Improvement.	Our procedures included: — **Controls tests:** We undertook the following controls tests: • We reviewed controls in relation to appropriate access to the ledger, authorisation of invoices, monitoring of contract performance and participation in the AoB exercise and found these to be adequately designed. — **Tests of details:** We undertook the following tests of details: • For a sample of the Trust's commissioners we agreed that signed contracts were in place and through testing a sample of invoices, that they had billed in line with the contract; • We assessed the outcome of the AoB exercise with other NHS bodies. Where there were mismatches over £300,000 we obtained evidence to support the Trust's reported income figure; • We tested a sample of non-NHS income items to 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. There is no material accrued or deferred income balances at year-end; and • We tested post year-end receipts to determine that these have been recognised in the correct period.
Recognition of expenditure Non pay expenditure: £27.4 million (2018/19: £24.6 million) Creditor accruals: £2.5 million (2018/19: £3.4 million) *Refer to page 51 (Audit Committee Report), page 96 (accounting policy) and page 111 (financial disclosures)*	**Effect of irregularities** In the public sector auditors consider the risk that material misstatements due to fraudulent financial reporting may arise from the manipulation of expenditure recognition (for instance by deferring expenditure to a later period). This may arise due to the audited entity manipulating expenditure to meet externally set targets. In 2019/20 the Trust reported total expenditure of £80.0m (2018/19, £73.2m). Of this £52.7m (2018/19: £48.7m) relates to employee benefits paid to staff, executive and non-executive directors. This represents 66% of total expenditure (2018/19: 67%). The remaining £27.4m (2018/19: £24.6m) was from supplies and services, purchase of healthcare from other bodies and professional fees.	Our procedures included: — **Controls tests:** We undertook the following controls tests: • We reviewed controls in relation to approval of purchases and found there to be exceptions in 4/25. In response, we increased our sample testing of expenditure items and have raised a recommendation regarding this in our year-end report. — **Tests of details:** We undertook the following tests: • We tested a sample of expenditure items to third party notifications to verify completeness and accuracy of transactions in the financial statements; • We assessed the reasonableness of the methodology used to estimate year-end expenditure accruals by assessing how a sample of prior year accruals had crystallised; • We assessed the reasonableness of the recognition and valuation of year-end provisions; and • We tested post year-end payments to determine that these have been recognised in the correct period.

4. Our application of materiality

Materiality for the Trust financial statements as a whole was set at £1.4 million (2018/19: £1.5 million), determined with reference to a benchmark of operating income (of which it represents approximately 2%) (2018/19: 2%). We consider operating income to be more stable than a surplus or deficit related benchmark.

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £70,000 (2018/19: £75,000), in addition to other identified misstatements that warranted reporting on qualitative grounds.



5. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2019/20.

Corporate governance disclosures

We are required to report to you if:

— we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy; or

— the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or

— the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2019/20, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 70, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

— any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006; or

— 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 these respects.

Our conclusion in respect of our work on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources is qualified

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

Qualified conclusion

Subject to the matters outlined in the basis for qualified conclusion paragraph below we are satisfied that in all significant respects Queen Victoria Hospital NHS Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2020.

Basis for qualified conclusion

In considering the Trust's arrangements for securing financial sustainability and its arrangements for challenging how it secures economy, efficiency and effectiveness we identified the following:

- The Trust was issued a £0.5m surplus control total for 2019/20, including a non-recurrent provider sustainability fund (PSF) allocation of £0.7m. The Trust did not sign up to this control total and resubmitted a plan in line with the financial deterioration in 2018/19 of £7.2m deficit;
- The Trust incurred a deficit of £9.2m in 2019/20, which met the revised plan submitted to NHSI in January 2020. This has been driven by shortfalls in income, overspends on non-pay and a corresponding loss of entitlement to PSF;
- The Trust has set a deficit budget of £9.0m for 2020/21, which would result in a cumulative deficit of £22.3m as at 31 March 2021. The Trust has been unable to accept the control total issued which is a target of breakeven with no support from the Financial Recovery Fund;
- The Trust has loans totalling £11.5m as at 31 March 2020, of which £7m fall due within 12 months. However, this includes £6.4m of revenue loans which will be replaced with public dividend capital in 2020/21 and therefore will not require cash repayment; and
- The Trust had a Cost Improvement Plan (CIP) totalling £1.8m for 2019/20, of which it achieved £1.2m. For 2020/21 the Trust is targeting a £1.2m CIP, of which £0.6m has been identified to date.

These issues are evidence of weaknesses in the Trust's arrangements for planning finances effectively to support the sustainable delivery of its strategic priorities and maintaining statutory functions

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

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources

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 the 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 the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risks identified during our risk assessment are set out overleaf together with the findings from the work we carried out on each area.

Significant Risk	Description	Work carried out and judgements
Financial sustainability	Sustainable resource deployment is key to the effective management of Trust resources and the longer term financial and operational future of the Trust.	Our work was undertaken under the NAO's VFM sub criteria of sustainable resource deployment, and included: — Assessing the Trust's performance in 2019/20 in achieving its plan, comparing actual outturn versus planned budgets and investigating reasons for variations; — Assessing the delivery of planned Cost Improvements Plans (CIPs) in 2019/20 and the planned CIPs for 2020/21; — Considering the financial operating run rate for 2019/20 and planned rates for 2020/21, including the Trust's understanding of its underlying run rate position and how this has tracked; — Critically assessing the Trust's liquidity position, including its forward cashflow position and loan compliance; and — Considering the reports of the Trust's regulators, including the Care Quality Commission and NHS Improvement. Our findings evidence weaknesses in the Trust's arrangements for planning finances effectively to support the sustainable delivery of its strategic priorities and maintaining statutory functions

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 and the terms of our engagement by the Trust. 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 the further matters we are required to state to them in accordance with the terms agreed with the Trust, 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 COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Queen Victoria Hospital NHS Foundation Trust for the year ended 31 March 2020 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

Chartered Accountants
15 Canada Square
London
E14 5GL
24 June 2020

6 Annual accounts 2019/20

Forward to the accounts
These accounts for the year ended 31 March 2020 have been prepared by Queen Victoria Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Steve Jenkin
Chief Executive
22 June 2020

Statement of Comprehensive Income for the period ended 31 March 2020

	Note	2019/20 £000	2018/19 £000
Operating income from patient care activities	3	69,052	65,978
Other operating income	4	3,347	4,670
Operating expenses	5-7	(80,006)	(73,265)
Operating surplus / (deficit)		**(7,607)**	(2,617)
Finance income	10	25	38
Finance expense - unwinding of discount on provisions	10	3	(2)
Finance expense - other	10	(252)	(174)
PDC dividends payable		(1,325)	(1,372)
Net finance costs		**(1,549)**	(1,510)
Other gains / (losses)	10	15	-
Retained surplus / (deficit) for the year		**(9,141)**	(4,127)
Other comprehensive income: (see statement of Changes in Taxpayers' Equity on page 93)			
Will not be reclassified to income and expenditure:			
Revaluation gains on property, plant and equipment	12	4,159	1,406
Impairment through revaluation reserve	12	(3,189)	(22)
Other reserve movements		-	-
Total comprehensive income / (expense) for the period (The notes on pages 95-131 form part of these accounts)		**(8,171)**	(2,743)

Statement of Financial Position as at 31 March 2020

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	11	2,279	1,555
Property, plant and equipment	12	50,375	49,618
Receivables	15	227	-
Total non-current assets		**52,882**	51,173
Current assets			
Inventories	14	1,153	1,275
Receivables	15	8,543	10,210
Cash and cash equivalents	16	2,910	3,944
Total current assets		**12,606**	15,429
Current liabilities			
Trade and other payables	17	(11,792)	(12,212)
Borrowings	18	(7,332)	(824)
Provisions	19	(62)	(59)
Other liabilities	18	(437)	(69)
Total current liabilities		**(19,623)**	(13,164)
Total assets less current liabilities		**45,865**	53,438
Non-current liabilities			
Provisions	19	(881)	(608)
Long term borrowings	18	(4,512)	(5,045)
Total non-current liabilities		**(5,393)**	(5,653)
Total assets employed		**40,472**	47,785
Financed by taxpayers' equity:			
See statement of Changes in Taxpayers' Equity on page 93			
Public dividend capital		13,106	12,249
Revaluation reserve		13,689	13,141
Income and expenditure reserve		13,677	22,395
Total taxpayers' equity		**40,472**	47,785

These accounts were approved by the Board on 19 June 2020 and are signed on the Board's behalf by:

Steve Jenkin
Chief Executive
22 June 2020

The notes on pages 95-131 form part of these accounts

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Total
2019/20	**£000**	**£000**	**£000**	**£000**
Taxpayers' equity at 1 April 2019	**12,249**	**13,142**	**22,395**	**47,786**
Retained Surplus for the year	-	-	(9,141)	**(9,141)**
Revaluation of property, plant and equipment	-	4,159	-	**4,159**
Impairments (Net)	-	(3,189)	-	**(3,189)**
Public Dividend Capital received	857	-	-	**857**
Public dividend capital repaid	-	-	-	**-**
Other reserve movements		(423)	423	**-**
Taxpayers' equity at 31 March 2020	**13,106**	**13,689**	**13,677**	**40,472**

2018/19				
Taxpayers' equity at 1 April 2018	12,237	12,182	26,098	50,517
Impact of implementing IFRS 15 on 1 April 2018	-	-	-	-
Impact of implementing IFRS 9 on 1 April 2018	-	-	-	-
Retained Surplus for the year	-	-	(4,127)	(4,127)
Revaluation of property, plant and equipment	-	1,406	-	1,406
Impairments	-	(22)	-	(22)
Public Dividend Capital received	12	-	-	12
Public dividend capital repaid	-	-	-	-
Other reserve movements		(424)	424	-
Taxpayers' equity at 31 March 2019	12,249	13,142	22,395	47,786

The notes on pages 95-131 form part of these accounts

Information on reserves

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 organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

STATEMENT OF CASH FLOWS

	Notes	2019/20	2018/19
		£000	£000
Operating Surplus / (Deficit)		**(7,607)**	(2,617)
Non-cash income and expense			
Depreciation and amortisation	5	**3,445**	2,957
Impairments and reversals	5	**397**	(759)
Income recognised in respect of capital donations	4	**(564)**	(499)
(Increase)/decrease in inventories	14	**122**	(97)
(Increase) / decrease in receivables and other assets	15	**1,461**	(1,041)
Increase/(decrease) in trade and other payables	17	**(499)**	3,296
Increase/(decrease) in provisions	19	**279**	(0)
Increase/(decrease) in other liabilities	18	**368**	(96)
Net cash generated from / (used in) operating activities		**(2,598)**	1,144
Cash flows from investing activities			
Interest received	10	**25**	38
Payments to acquire intangible assets	11	**(1,012)**	(981)
Payments to acquire property, plant and equipment	12	**(2,702)**	(3,217)
Sales of PPE		**15**	-
Receipt of cash donations to purchase capital assets		**432**	400
Net cash generated from/(used in) investing activities		**(3,242)**	(3,760)
Cash flows from financing activities			
Public dividend capital received		**857**	12
Movement in loans from the Department of Health and Social Care	21.1	**5,613**	(779)
Capital element of finance lease rental payments		**(78)**	-
Interest on loans paid	20	**(210)**	(181)
Interest element of finance lease		**(5)**	-
PDC dividend paid		**(1,371)**	(1,406)
Net cash generated from/(used in) financing activities		**4,806**	(2,355)
Increase/(decrease) in cash and cash equivalents		**(1,034)**	(4,971)
Cash and cash equivalents at 1 April	16	**3,944**	8,914
Cash and cash equivalents at 31 March	16	**2,910**	3,944

The notes on pages 95-131 form part of these accounts

Notes to the financial statements

1 Accounting policies

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2019/20 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These 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 Going concern

These accounts have been prepared on a going concern basis.

The Trust is required under International Accounting Standard 1 to undertake an assessment of the NHS Foundation Trust's ability to continue as a going concern. Due to the materiality of the financial deficit, the Board has carefully considered whether the accounts should be prepared on the basis of being a going concern.

The board considered that the definition of going concern in the public sector focuses on the expected continued provision of services by the public sector rather than organisational form. The financial statements of all NHS providers and clinical commissioning groups will be prepared on a going concern basis unless there are exceptional circumstances where the entity is being or is likely to be wound up without the provision of its services transferring to another entity in the public sector.

The factors taken into consideration are set out below.

Control total

The 2020/21 financial control total for the Trust issued on 4 October 2019 from NHS Improvement is that the Trust should breakeven with no support from the Financial Recovery Fund. The control total was set on the basis of 2018/19 control total, which had not been accepted by the Trust board, and did not reflect the material deterioration in the Trust's financial position or the 2018/19 and 2019/20 year-end positions. The Trust has therefore not been able to accept the allocated control total for 2020/21 and was forecasting a draft deficit in 2020/21 of £8.7m based on the business planning guidance pre COVID-19. Due to the change in guidance the forecast year end position is unclear for 2020/21, however at present the cumulative deficit for the prior two years remains at £13.3m.

Year-end contract agreements for 2019/20

In March 2020 in line with national guidance all non-urgent elective operations were to free-up the maximum possible inpatient and critical care capacity as part of the COVID-19 response requirement. After the year-end agreements were put in place with commissioners to protect the Trust against loss of income from this reduction in elective activity. The Trust was on Payment by Results contracts with commissioners in 2019/20, and agreements were reached with all contract commissioners to fund the Trust to year-end based on the January and February 2020 activity forecast outturn. Payments were also provided centrally to cover the costs of COVID-19 related work carried out during 2019/20 which included funding any loss of

income for non-contract activity.

Contracts for 2020/21
The operational planning process and contracting round has been suspended for 2020/21 and amended financial arrangements have been put in place due to COVID-19 preparations.

For 2020/21, NHS England is providing a guaranteed minimum level of income reflecting the Trust's current cost base until 31 October 2020 – an annualised £66.5m. This is based on the average monthly expenditure implied by the Trust's December 2019 Agreement of Balances return and includes an uplift for inflation without any tariff efficiency factor being applied.

Prior to the suspension of planning in February 2020, the Trust submitted a draft operating plan based on 2019/20 demand and capacity. The guaranteed block income received from NHS England for 2020/21 is in line with the commissioner income included in the draft operating plan, excluding planned income from waiting list initiatives and commissioner notice items relating to proposed tariff increases.

The block funding will not be revised to reflect any short falls in normal contractual performance until at least 31 July 2020 and all contract sanctions are suspended. The Trust will also be able to claim monthly for additional costs where block payments do not equal actual costs to reflect genuine and reasonable additional marginal costs due to COVID-19. Examples of this would include increases in temporary staffing to cover increased levels of sickness absence, or increased non-pay costs in dealing with COVID-19 activity.

Non-England (any activity outside of Department of Health and Social Care scope, including Wales and Scotland), non-contract activity in 2020/21 is likely to be impacted by elective activity reductions for at least the first four months of the year. The Trust will continue to invoice separately for this, and for services provided to other NHS providers, on the basis of amounts invoiced in 2019/20 without any inflationary uplift, regardless of level of service provided. A national top-up payment will be provided to reflect the difference between actual costs and non-contract, non-England income, where the expected cost base is higher.

These provisions are in place with an overall aim of ensuring the Trust reaches a break-even position during the first seven months 2020/21. The Financial Recovery Fund and associated rules are also suspended during this period.

The financial regime post-31 October remains uncertain at this stage due to the unpredictability of the demand on the system for the treatment of COVID-19 patients. Further guidance is awaited as to when the planning process will recommence.

Service provision in 2021/22 and beyond
Looking further ahead, the Trust has reasonable expectations that services will continue to be provided by QVH in 2021/22. As part of the response to the pandemic, QVH has taken on the role of being the cancer surgery hub for Kent, Surrey and Sussex for head and neck, skin and breast cancer patients. It is expected that significant elective activity in these specialist areas will be required as part of the restoration and recovery period following the pandemic. In the longer term, the Trust is considering whether being part of a hospital group could help with its long term financial sustainability.

Cost improvement and efficiency plans
Due to the block contract arrangement, the Trust is not required to develop and deliver efficiency plans over the block contract time period, however due to the Trusts deteriorating financial position and the requirement to achieve break even in the coming years the Trust is pushing forward with efficiency plans. At present £0.6m of efficiencies for 20/21 have been identified against a target of £1.2m (2019/20 achieved £1.2m against a target of £1.8m), however the risk remains that the spending and activity patterns of the Trust have changed so significantly that the pre COVID-19 identified plans may, at present, not be achievable.

Cash flow
The Trust expects to receive cash support in line with the block contract arrangement until at least 31 October 2020, in line with the statement from NHS England and NHS Improvement to support provider and commissioner forecasting. The Trust is awaiting central guidance as to the cash flow support which will be available post block contract arrangements. Due to the Trust's material deficit, the Trust will need

significant on-going cash support for the 12 month period from the date of approval of these accounts which is undetermined at present and unconfirmed but is expected to be material.

Loans
On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. Given this relates to liabilities that existed at 31 March 2020, DHSC has updated its Group Accounting Manual to advise this is considered an adjusting event after the reporting period for providers.

Outstanding interim loans totalling £6.4m as at 31 March 2020 in these financial statements have been classified as current as they will be repayable within 12 months.

The loans received for the theatre build totalling £10.1m are not affected by the reforms described above and will remain due. Payment terms remain the same as the loan agreement dated 20 June 2011, 3.85% of the principal debt repayable every 6 months from December 2013 to June 2026.

Key risks to the financial plan
The key risks to the financial plan are based in the high level of uncertainty in the current pandemic situation. This includes:

- Block contracts have been agreed to 31 October 2020, but it is unlikely that health services will be able to operate in a normal way at this stage. The increased levels of PPE and screening of patients significantly reduces the efficiency of theatre activity, and national instructions on the stratification of elective work to prioritise clinical need will impact on case mix. If the block contract comes to an end in year, these factors will have an impact on income which it is not possible to assess at this stage.

- There is uncertainty as to the continuation of the national contract with the independent sector. This contract is currently supporting the separation of trauma and cancer patients on the East Grinstead site. If the Trust is unable to make use of the independent sector facilities there will be a significant impact on activity.

- Ongoing work across the Sussex Health and Care Partnership (integrated care system) and through the cancer networks as part of the pandemic recovery work may lead to in year changes in which services are provided by QVH.

- In the suspended business planning guidance 1.6% of efficiencies were required for trusts in deficit. For QVH this would be £1.2m. At present £0.6m have been identified and £0.6m is unidentified. The Trust is mindful that the identified efficiencies may not materialise in year due to differing spending patterns under the current activity arrangements.

- Uncertainties around the impact of Brexit on the cost of pharmaceuticals, medical devices and potential impact on the NHS workforce.

The Trust still faces a material deficit based on the original 2020/21 business planning guidance for tariff. This year the Trust was anticipating Financial Recovery Funding through the Sussex Health and Care Partnership, however due to the current arrangements this is not required but will still be a requirement post block contract arrangements.

Directors' statement regarding going concern

After making enquiries, the directors have concluded that there is sufficient evidence that services will continue to be provided. In reaching this conclusion, the board considered the financial provision within the forward plans of commissioners; efficiency plans and the recognised role of the Trust within the Sussex Health and Care Partnership and the wider regional health care system. The Trust's cash flow provision will be dependent on both acceptance and delivery of the financial recovery plans and support from the Department of Health and Social Care (DHSC). As with any Trust placing reliance on other DHSC group entities for financial support, the directors acknowledge that there can be no certainty that this support will

continue although, at the date of approval of these financial statements, they have no reason to believe that it will not do so.

Based on these indications the directors believe that it remains appropriate to prepare the accounts on a going concern basis. However, the matters referred to above represent a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern and, therefore, to continue realising its assets and discharging its liabilities in the normal course of business. The financial statements do not include any adjustments that would result from the basis of preparation being inappropriate.

1.2 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.

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts: The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

Revenue from research contracts: Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. At contract inception, the Trust assesses the outputs promised in the research contract to identify as a performance obligation each promise to transfer either a good or service that is distinct or a series of distinct goods or services that are substantially the same and that have the same pattern of transfer. The Trust recognises revenue as these performance obligations are met, which may be at a point in time or over time depending upon the terms of the contract.

NHS injury cost recovery scheme: The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Provider sustainability fund (PSF) and Financial recovery fund (FRF): The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

1.3 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 Pensions 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 Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employer's 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 Pensions Scheme is given in Note 9.

1.4 Expenditure on other goods and services (other expenses)

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.

1.5 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 external valuers (Gerald Eve LLP - RICS Registered Valuers, a regulated firm of Chartered Surveyors) in accordance with the requirements of the Valuation-Global Standards 2017, the International Valuation Standards and IFRS as adapted by FReM. 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 2020 as at the prospective valuation date of 31 March 2020 and are accounted for in the 2019/20 accounts.
The valuation report for this valuation contains a declaration of material valuation uncertainty due to the Covid-19 Global Pandemic and the impact on financial markets. The valuation may still be relied upon, but for transparency, less certainty should be attached to the valuation than would otherwise be the case.

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.

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 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 six 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 expenditure.

In accordance with the DHSC GAM, 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 expenditure 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 2020.

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 is not considered sufficient to affect values materially.

It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. On the basis of existing knowledge, outcomes within the next financial year that are different from the assumption around the valuation of our land, property, plant and equipment could require a material adjustment to the carrying amount of the asset or liability recorded in note 12.

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.

1.6 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.

1.7 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.

1.8 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.9 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 comprehensive 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 comprehensive income statement.

1.10 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.

1.11 Financial assets and financial liabilities

Recognition

Financial assets are recognised when the Trust becomes party to the contractual provision of the financial instrument or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or when the asset has been transferred and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.
This includes 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 and are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

The DHSC Group Accounting Manual expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

Financial assets at amortised cost:

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.

After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

Financial assets at fair value through other comprehensive income:

Financial assets measured at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.
The Trust does not have any assets in this category.

Financial assets at fair value through income and expenditure:

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term. The Trust does not have any assets in this category.

Impairment of financial assets

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Trust recognises a loss allowance representing expected credit losses on the financial instrument.

The Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

Trade receivables' expected credit losses are determined by reference to debt history and identified trends and the Injury Compensation Scheme receivables at 21.79% (21.89% 18-19) being the national average of claims not reaching payment (DHSC 2019-20).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage
2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

Financial Liabilities
Financial liabilities are recognised when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been extinguished – that is,
the obligation has been discharged or cancelled or has expired.

Financial liabilities at fair value through profit and loss:
Derivatives that are liabilities are subsequently measured at fair value through profit or loss, Embedded derivatives that are not part of a hybrid contract containing a host that is an asset within the scope of IFRS 9 are separately accounted for as derivatives only if their economic characteristics and risks are not closely related to those of their host contracts, a separate instrument with the same terms would meet the definition of a derivative, and the hybrid contract is not itself measured at fair value through profit or loss. The Trust does not have any financial liabilities in this category.

Other financial liabilities:
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

1.12 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating 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 commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost 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. 10 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.

1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources 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.
Early retirement provisions are discounted using HM Treasury's pension discount rate of negative 0.50% (2018-19: positive 0.29%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A nominal short-term rate of 0.51% (2018-19: positive 0.76% in real terms) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 0.55% 1.14% (2018-19 1.14% in real terms) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

Clinical negligence costs
NHS Resolution (NHSR) (previously NHS Litigation Authority (NHSLA)) operates a risk pooling scheme under which the Trust pays an annual contribution, which, in return, settles all clinical negligence claims. Although the NHSR is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHSR 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 NHS Resolution 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 NHSR and in return receives assistance with the cost 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.

1.14 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

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.15 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 organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

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 (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (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 the audit of the annual accounts.
The average relevant net assets is calculated as a simple average of opening and closing relevant net assets.

1.16 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 non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.17 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 2020.

1.18 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 as 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.

1.19 IASB standard and IFRIC interpretations

No new accounting standards or revisions to existing standards have been early adopted in 19-20

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.

ii) IFRS 16 - Leases
Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the re-measurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2021, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The Trust does not expect any material impact of applying IFRS 16 in 2021/22 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions. This is because the only current material lease is already accounted for as a finance lease.

iii) IFRS 17 - Insurance Contracts
Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

iv) IFRIC 23 - Uncertainty over Income Tax Treatments
Application required for accounting periods beginning on or after 1 January 2019.

1.20 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 £42,828,000 (2018/19 £42,481,000) - 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. The valuation report for this valuation contains a declaration of material valuation uncertainty due to the Covid-19 Global Pandemic and the impact on financial markets.

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 2019/20 financial year end, the estimated value of partially completed spells is £50,926 (2018/19 £38,264).

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 1.13 and 19.

1.21 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 and operate in a common economic environment utilising shared resources. They are also subject to the same regulatory environment and standards set by our external performance managers. Accordingly, the Trust operates one segment. The chief operating decision maker of the Trust is the Trust Board.

1.22 Consolidation of accounts

The Trust is the corporate trustee to the Queen Victoria Hospital NHS Trust Charitable Fund and as such has the power to govern its financial and operating policies so as to obtain benefits from its activities for itself, its patients and its staff. The income and assets of the charity are not considered to be material amounts in the context of the Trust's accounts and are therefore not consolidated.

1.23 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 FReM. Amounts held at the balance sheet date were negligible.

1.24 Losses and special payments

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

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.25 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

2. Operating segments

The Trust operates a single segment, the provision of healthcare.

	2019/20 £000s	2018/19 £000s
Income	**72,399**	70,648
Segment surplus (deficit)	**(9,141)**	(4,127)
Segment net assets	**40,472**	47,786

3. Income from patient care activities

Income from patient care activities by nature	2019/20 £000	2018/19 £000
Eyes	**6,595**	6,866
Oral	**12,358**	13,655
Plastics	**30,095**	29,869
Sleep	**5,078**	4,861
Other	**14,926**	10,727
	69,052	65,978

Income from patient care activities by source	2019/20 £000	2018/19 £000
Clinical commissioning groups and NHS England**	**65,665**	62,550
Department of Health and Social Care *	**-**	628
Other NHS providers	**1,211**	963
Private patients	**188**	228
Overseas patients (non-reciprocal, chargeable to patient)	**95**	3
Injury cost recovery scheme	**291**	94
Other	**1,602**	1,513
	69,052	65,978

Notes:

*Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff for individual services.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts. £1,977,000 has been included in the NHS England line.

"Injury cost recovery scheme " 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 21.79% to reflect expected rates of collection.

Commissioner Requested Services

Within the 2019/20 financial statements management has taken the view that commissioner requested services are those which are provided for the healthcare of NHS patients.

Of the total income reported above, £68,769,000, (2018/19 £65,747,000) was derived from the provision of commissioner requested services. (being all of the above except private and overseas patient income)

4. Other Operating Income

	2019/20	2018/19
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	**325**	293
Education and training	**1,600**	1,625
Non-patient care services to other bodies	**111**	385
Provider sustainability fund	**-**	995
Other contract income	**747**	873
Other non-contract operating income:		
Receipt of capital grants and donations	**564**	499
Other non contract income	**-**	-
	3,347	4,670

4.1 Additional information on revenue from contracts with customers recognised in the period

	2019/20	2018/19
	£000	**£000**
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	**69**	166
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	**-**	**-**

4.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2020	31 March 2019
	£000	**£000**
within one year	**-**	**-**
after one year, not later than five years	**-**	**-**
after five years	**-**	**-**
Total revenue allocated to remaining performance obligations	**-**	**-**

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

5. Operating Expenses	**2019/20**	2018/19
	£000	£000
Purchase of healthcare from non-NHS/DHSC bodies	**1,112**	221
Staff and executive directors costs	**52,572**	48,566
Remuneration of non-executive directors	**109**	114
Supplies and services - clinical (excluding drugs)	**11,984**	13,038
Supplies and services - general	**731**	917
Drugs	**1,429**	1,496
Inventories written down	**-**	30
Consultancy	**214**	367
Establishment	**822**	680
Premises (including rates)	**3,456**	2,883
Transport (including patient travel)	**567**	651
Depreciation	**3,157**	2,816
Amortisation	**288**	141
Impairments of property, plant and equipment (net)	**397**	(759)
Movement in credit loss allowance: contract receivables	**488**	(35)
Movement in credit loss allowance: all other receivables	**-**	-
Increase/(decrease) in other provisions	**-**	1
Change in provisions discount rate(s)	**58**	(14)
External audit : statutory audit	**65**	68
External audit : audit-related assurance services	**-**	8
Internal audit services	**105**	45
Clinical negligence (payable to NHS Resolution)	**788**	626
Legal fees	**11**	58
Insurance	**22**	36
Research and development (staff cost)	**320**	315
Education and training	**150**	49
Rentals under operating leases	**-**	217
Early retirements	**30**	16
Redundancy	**-**	-
Car parking & security	**219**	200
Hospitality	**3**	5
Losses, ex gratia & special payments	**8**	5
Other services, eg external payroll	**171**	92
Other	**730**	413
	80,006	73,265

Notes:

External Audit: The contract signed on 25/01/2017 states that the liability of KPMG, its members, partners and staff (whether in contract, negligence or otherwise) shall in no circumstances exceed £1,000,000 aside from where the liability cannot be limited by law. This is in aggregate in respect of all services.

External audit fees for the statutory audit of financial statements 2019-20, exclusive of VAT, were £54,435.

6. Operating leases

As lessee

Operating leases relate to buildings, medical equipment and vehicles.

The building lease has been extended for a further period of five years from April 2019 and has been classified as a

All leases of medical equipment and vehicles are now expired.

Payments recognised as an expense	**2019/20 £000**	2018/19 £000
Minimum lease payments	**0**	217

Total future minimum lease payments	**31 March 2020 £000**	31 March 2019 £000
Payable:		
Not later than one year	**-**	83
Between one and five years	**-**	334
After 5 years	**-**	-
Total	**-**	417

7. Employee benefits and staff numbers

7.1 Employee benefits	**2019/20 £000**	2018/19 £000
Salaries and wages	**40,093**	37,681
Social Security Costs	**3,936**	3,831
Apprenticeship levy	**182**	170
Employer's contributions to NHS Pension scheme*	**6,492**	4,210
Pension cost - other	**14**	11
Agency/contract staff	**2,810**	3,351
Total gross staff costs	**53,527**	49,254
Recoveries in respect of seconded staff	**(37)**	-
Total staff costs	**53,490**	**49,254**
Of which - costs capitalised as part of assets	**598**	373
Total staff costs excluding capitalised costs	**52,892**	**48,881**

*The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts. £1,977,000 of nominal cost has been included in the costs for 2019/20.

More detailed staff cost disclosures may be found in the accountability report.

8. Retirements due to ill-health

During 2019/20 there was 1 early retirement from the Trust agreed on the grounds of ill-health incapacity (none in the year ended 31 March 2019). The estimated additional pension liabilities of this ill-health retirement is £12k (0k in 2018/19).

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 is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme 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 recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6%, and the Scheme Regulations were amended accordingly.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

10. Finance Income

	2019/20 £000	2018/19 £000
Interest on bank accounts	**25**	38

10.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

Interest expense:	2019/20 £000	2018/19 £000
Loans from the Department of Health and Social Care	**247**	174
Other loans	**-**	-
Overdrafts	**-**	-
Finance leases	**5**	-
Interest on late payment of commercial debt	**-**	-
Total interest expense	**252**	174
Unwinding of discount on provisions (see note 19)	**(3)**	2
Other finance costs	**-**	-
Total finance costs	**249**	176

10.2 Other gains / (losses)

	2019/20 £000	2018/19 £000
Gains on disposal of assets	**15**	-
Losses on disposal of assets	**-**	-
Total gains / (losses) on disposal of assets	**15**	-
Gains / (losses) on foreign exchange	**-**	-
Other gains / (losses)	**-**	-
Total other gains / (losses)	**15**	-

11. Intangible Assets

Software Licences	2019/20 £000	2018/19 £000
Gross cost at 1 April	**3,026**	2,045
Additions	**1,012**	981
Disposals	**-**	-
Gross cost at 31 March	**4,038**	3,026
Amortisation at 1 April	**1,471**	1,330
Provided during the year	**288**	141
Amortisation at 31 March	**1,759**	1,471
Net book value		
- Purchased assets at 1 April	**1,555**	715
- Purchased assets at 31 March	**2,279**	1,555

12. Property, plant and equipment

12.1 Property, plant and equipment at 31 March 20 20

	Land	Buildings	Assets under construction	Plant and Machinery	Information Technology	Total
	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2019	5,990	36,491	391	15,083	6,738	**64,693**
Additions - purchased	-	252	781	550	803	**2,386**
Additions - leased	-	402	-	-	-	**402**
Additions - donated	-	124	27	403	10	**564**
Reclassifications	-	477	(563)	-	86	**-**
Impairments recognised in operating expenses	(178)	(884)	-	-	-	**(1,062)**
Reversal of impairments	-	665	-	-	-	**665**
Impairments recognised in revaluation reserve	(1,852)	(1,337)	-	-	-	**(3,189)**
Revaluation	-	4,159	-	-	-	**4,159**
Accumulated depreciation transferred on revaluation	-	(1,481)	-	-	-	**(1,481)**
Disposals	-	-	(11)	-	-	**(11)**
At 31 March 2020	**3,960**	**38,868**	**625**	**16,036**	**7,637**	**67,126**
Depreciation at 1 April 2019	-	-	-	12,191	2,883	**15,074**
Provided during the year	-	1,481	-	988	688	**3,157**
Accumulated depreciation transferred on revaluation	-	(1,481)	-	-	-	**(1,481)**
Disposals	-	-	-	-	-	**-**
Depreciation at 31 March 2020	**-**	**-**	**-**	**13,179**	**3,571**	**16,750**
Net book value						
- Purchased assets as at 1 April 2019	5,990	34,304	391	2,338	3,851	**46,873**
- Donated assets as at 1 April 2019	-	2,187	-	554	4	**2,745**
Total at 1 April 2019	**5,990**	**36,491**	**391**	**2,892**	**3,855**	**49,618**
- Purchased assets as at 31 March 2020	3,960	36,886	598	2,056	4,055	**47,554**
- Donated assets as at 31 March 2020	-	1,982	27	801	11	**2,821**
Total at 31 March 2020	**3,960**	**38,868**	**625**	**2,857**	**4,066**	**50,375**

2018-19 comparators:	Land	Buildings	Assets under construction	Plant and Machinery	Information Technology	Total
	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2018	5,450	34,808	1,976	14,005	4,223	60,461
Additions - purchased	-	890	808	679	542	2,919
Additions - donated	-	100	-	399	-	499
Reclassifications	-	420	(2,393)	-	1,973	-
Impairments recognised in operating expenses	-	(183)	-	-	-	(183)
Reversal of impairments	-	942	-	-	-	942
Impairments recognised in revaluation reserve	-	(22)	-	-	-	(22)
Revaluation	540	866	-	-	-	1,406
Accumulated depreciation transferred on revaluation	-	(1,330)	-	-	-	(1,330)
Disposals	-	-	-	-	-	0
At 31 March 2019	5,990	36,491	391	15,083	6,738	64,693
Depreciation at 1 April 2018	-	-	-	11,185	2,403	13,588
Provided during the year	-	1,330	-	1,006	480	2,816
In-year depreciation transferred on revaluation	-	(1,330)	-	-	-	(1,330)
Disposals	-	-	-	-	-	0
Depreciation at 31 March 2019	-	-	-	12,191	2,883	15,074
Net book value						
- Purchased assets as at 1 April 2018	5,450	32,750	1,976	2,545	1,809	44,531
- Donated assets as at 1 April 2018	-	2,058	-	274	10	2,342
Total at 1 April 2018	5,450	34,808	1,976	2,820	1,820	46,873
- Purchased assets as at 31 March 2019	5,990	34,304	391	2,338	3,851	46,873
- Donated assets as at 31 March 2019	-	2,187	-	554	4	2,745
Total at 31 March 2019	5,990	36,491	391	2,892	3,855	49,618

12.2 Fully depreciated assets

Fully depreciated assets with an aggregate gross carrying value of £14,381,000 were in use at 31 March 2020.

12.3 Property, plant and equipment donated during the year

The League of Friends of the Queen Victoria Hospital and the Queen Victoria NHS Trust Charitable Fund donated capital items with a combined value of £95,000. £450,000 was granted by NHS Health Education England for the creation and equipping of a dental training facility.

13. Capital commitments

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

	31 March 2020	31 March 2019
	£000	£000
Property, plant and equipment	**232**	101

14. Inventories

Inventories at 31 March	**31 March 2020**	31 March 2019
	£000	£000
Drugs	**194**	129
Consumables	**960**	1,147
Total	**1,153**	1,275

15. Receivables

15.1 Receivables comprise:

	31 March 2020	31 March 2019
Current receivables	**Current £000**	Current £000
Contract receivables*	**8,746**	10,062
Contract assets	**-**	-
Allowance for impaired contract receivables / assets	**(1,241)**	(753)
Allowance for other impaired receivables	**-**	-
Prepayments	**645**	794
PDC dividend receivable	**21**	-
VAT receivable	**98**	**-**
Other receivables	**274**	107
Total current trade and other receivables	**8,543**	10,210
Non Current receivables		
Other receivables**	**227**	-

** The provision for the cost for the clinician pension tax scheme is offset with an associated future funding stream.

*The majority of trade was with Clinical Commissioning Groups and NHS England as commissioners for NHS patient care services. Both were funded by Government to buy NHS patient care services and so no credit scoring of them is considered necessary.

15.11 Allowances for credit losses

Contract receivables and contract assets	**2019/20**	2018/19
Allowances for credit losses	**£000**	£000
Allowances as at 1 April - brought forward	753	-
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	0	788
Allowances at start of period for new FTs	**-**	-
Transfers by absorption	**-**	-
New allowances arising	784	(35)
Changes in existing allowances	**-**	-
Reversals of allowances	**(296)**	-
Utilisation of allowances (write offs)	**-**	-
Changes arising following modification of contractual cash flows	**-**	-
Foreign exchange and other changes	**-**	
Allowances as at 31 March	**1,241**	753

15.2 Receivables past their due date but not impaired

	31 March 2020	31 March 2019
	£000	£000
By up to three months	**4,728**	2,494
By between three and six months	**573**	918
By more than six months	**1,052**	2,366
Total	**6,353**	5,778

15.3 Provision for impairment of NHS receivables

	2019/20	2018/19
	£000	£000
Balance at 1 April	**(549)**	(561)
Amount recovered or written off during the year	**294**	12
Increase in receivables impaired	**(511)**	-
Balance at 31 March	**(766)**	(549)

The provision represents amounts which are either considerably beyond their due date, known to be under challenge or which the Trust considers may be disputed by the debtor body.

15.4 Provision for impairment of non-NHS receivables

	2019/20	2018/19
	£000	£000
Balance at 1 April	**(203)**	(227)
Amount recovered or written off during the year	**2**	24
Increase in receivables impaired	**(274)**	-
Balance at 31 March	**(475)**	(203)

16. Cash and cash equivalents

	2019/20	2018/19
	£000	£000
Balance at 1 April	**3,944**	8,914
Net change in year	**(1,034)**	(4,970)
Balance at 31 March	**2,910**	3,944
Comprising:		
Cash with the Government Banking Service (GBS)	**2,508**	2,691
Commercial banks and cash in hand	**402**	1,253
Cash and cash equivalents as in statement of cash flows	**2,910**	3,944

17. Trade and other payables

	31 March 2020	31 March 2019
	£000	£000
Trade payables	**6,160**	5,500
Capital payables	**1,142**	1,038
Accruals	**2,450**	3,426
Receipts in advance (including payments on account)	**-**	-
Social security costs	**594**	527
VAT payables	**-**	275
Other taxes payable (e.g. PAYE, Levy)	**519**	536
PDC dividend payable	**-**	25
NHS Pension payables	**652**	713
Other payables	**275**	172
Total	**11,792**	12,212

18. Other liabilities-Deferred income

Current	31 March 2020	31 March 2019
	£000	£000
Deferred income	**207**	69
Deferred grants	**230**	-
Total	**437**	69

18.1 Borrowings

	31 March 2020	31 March 2019
	£000	£000
Current		
Bank overdrafts	**-**	-
Drawdown in committed facility	**-**	-
Loans from DHSC*	**7,253**	824
Other loans	**-**	-
Obligations under finance leases	**79**	-
Obligations under PFI, LIFT or other service concession contracts	**-**	-
Total current borrowings	**7,332**	824
Non-current		
Loans from DHSC (Capital loan)	**4,267**	5,045
Other loans	**-**	-
Obligations under finance leases	**245**	-
Obligations under PFI, LIFT or other service concession contracts	**-**	-
Total non-current borrowings	**4,512**	5,045

* This includes £6,391k of revenue loans which will be replaced with public dividend capital in 2020-21 and therfore will not require cash repayment.

18.2 Queen Victoria Hospital NHS Foundation Trust as a lessee:
Obligations under finance leases where the trust is the lessee.

	31 March 2020	31 March 2019
	£000	£000
Gross lease liabilities	**324**	-
of which liabilities are due:		
not later than one year;	**79**	-
later than one year and not later than five years;	**245**	-
later than five years.	**-**	-
Finance charges allocated to future periods	**-**	-
Net lease liabilities	**324**	-
of which payable:		
not later than one year;	**79**	-
later than one year and not later than five years;	**245**	-
later than five years.	**-**	-
Total payable	**324**	-

19. Provisions

Current provisions	31 March 2020	31 March 2019
	£000	£000
Pensions relating to staff	**36**	29
Legal claims	**26**	30
Total	**62**	59

Non-current provisions	31 March 2020	31 March 2019
	£000	£000
Pensions relating to staff	**881**	608
Total Provisions	**943**	667

19.1 Provisions (movements by type)

Movements in-year	Pensions - Early departures	Pensions injury benefits	Legal claims	Other	Total
	£000	**£000**	**£000**	**£000**	**£000**
At 1 April 2019	36	601	30	-	**667**
Change in discount rate	1	57	-	-	**58**
Arising during the year	3	25	6	227	**261**
Used during the year	(8)	(22)	-	-	**(30)**
Reversed unused	-	-	(10)	-	**(10)**
Unwinding of discount	-	(3)	-	-	**(3)**
At 31 March 2020	**32**	**658**	**26**	**227**	**943**
Expected timing of cash flows:					
Within one year	8	28	26	-	**62**
Between one and five years	24	113	-	-	**137**
After five years	(0)	517	-	227	**744**
	32	**658**	**26**	**227**	**943**

The provisions for pensions 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 liability 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.

£1,243,000 was included in the provisions of NHS Resolution at 31 March 2020 in respect of clinical negligence liabilities of the Trust (31 March 2019 £1,005,000) (NHS Litigation Authority).

"Other" provisions of £227,000 is for the reimbursement of the clinicians' pension tax scheme which will be funded through the DHSC.

20. Finance expense

See note 10

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. Carrying values are taken as a reasonable approximation of fair value.

Financial assets	31 March 2020	31 March 2019
	£000	£000
Receivables (excluding non financial assets) - with DHSC group bodies	**6,121**	7,231
Receivables (excluding non financial assets) - with other bodies	**1,885**	2,185
Other investments / financial assets	**-**	-
Cash and cash equivalents	**2,910**	3,944
Total	**10,916**	**13,360**

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 2020	31 March 2019
Carrying value:	£000	£000
Loans from the Department of Health and Social Care	**11,520**	5,869
Obligations under finance leases	**324**	-
Trade and other payables (excluding non financial liabilities) - with DHSC group bodies	**3,772**	4,156
Trade and other payables (excluding non financial liabilities) - with other bodies	**6,907**	6,693
Total	**22,523**	16,718

"Borrowings" represents a loan from the Foundation Trust Financing Facility provided by the Department of Health & Social Care.

All financial liabilities are classified as "other financial liabilities", with no financial liabilities being classified as "liabilities at fair value through the statement of comprehensive income".

Taxes are not included as they are not contractual and not classed as Financial Instruments. Injury Cost Recovery Scheme receivables are now classed as contractual and as financial instruments.

21.2 Maturity of financial assets

All of the Trust's financial assets mature within one year.

21.3 Maturity of financial liabilities

The Trust's financial liabilities fall due within one year with the exception of £245,000 of the finance lease and £4,267,000 portion of the DHSC loan.

Financial liabilities fall due in:	31 March 2020	31 March 2019
In one year or less	**18,011**	11,673
In more than one year but not more than two years	**859**	778
In more than two years but not more than five years	**2,498**	2,334
In more than five years	**1,155**	1,933
	22,523	16,718

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 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 exposure as at 31 March 2020 are in receivables from customers, as disclosed in note 15.

Liquidity risk

The Trust's operating costs are incurred under contracts with NHS England and 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 2019/20, (2018/19 none).

The Department of Health and Social Care is the parent department, 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.

The Trust received donations from the Queen Victoria Hospital NHS Trust Charitable Fund, the trustee of which is Queen Victoria Hospital NHS Foundation Trust.

The total income and expenditure transactions with the charity for the year are shown below.

	2019/20		2018/19	
	Income	**Expenditure**	Income	Expenditure
	£000	**£000**	£000	£000
The Queen Victoria Hospital NHS Trust Charitable Fund	**149**	**-**	171	-

22. Related Party Transactions (cont.)

Whole of Government Accounts bodies with significant transactions relationship (approx £100k)

Income and Expenditure	2019/20		2018/19	
	Income	**Expenditure**	Income	Expenditure
	£000	**£000**	£000	£000
Brighton and Sussex University Hospitals NHS Trust	**654**	**895**	298	1,089
Guy's & St Thomas' NHS Foundation Trust	**21**	**9**	132	(2)
Maidstone and Tunbridge Wells NHS Trust	**156**	**84**	187	82
Dartford and Gravesham NHS Trust	**-**	**877**	-	660
Medway NHS Foundation Trust	**1**	**962**	1	930
East Sussex Healthcare NHS Trust	**-**	**700**	-	935
Sussex Community NHS Foundation Trust	**174**	**11**	263	56
Surrey And Sussex Healthcare NHS Trust	**1**	**78**	97	231
East Kent Hospitals University NHS Foundation Trust	**1**	**44**	-	102
Northumbria Healthcare NHS Foundation Trust	**-**	**219**	-	109
NHS Resolution (formerly NHS Litigation Authority)	**-**	**788**	-	626
Care Quality Commission	**-**	**52**	-	48
Health Education England	**1,551**	**-**	1,600	-
NHS England	**23,545**	**105**	23,466	-
NHS Ashford CCG	**499**	**-**	417	-
NHS Bexley CCG	**267**	**-**	369	-
NHS Brighton and Hove CCG	**1,219**	**-**	1,204	-
NHS Bromley CCG	**687**	**-**	662	-
NHS Canterbury and Coastal CCG	**618**	**-**	589	-
NHS Coastal West Sussex CCG	**3,485**	**-**	3,119	-
NHS Crawley CCG	**2,017**	**-**	2,083	-
NHS Croydon CCG	**261**	**-**	276	-
NHS Dartford, Gravesham and Swanley CCG	**2,195**	**-**	2,346	-
NHS East Surrey CCG	**2,841**	**-**	2,571	-
NHS Eastbourne, Hailsham and Seaford CCG	**1,528**	**-**	1,273	-
NHS Guildford and Waverley CCG	**642**	**-**	535	-
NHS Hastings and Rother CCG	**2,083**	**-**	1,546	-
NHS High Weald Lewes Havens CCG	**4,350**	**-**	3,877	-
NHS Horsham and Mid Sussex CCG	**5,931**	**-**	6,365	-
NHS Medway CCG	**2,304**	**-**	2,516	-
NHS North West Surrey CCG	**204**	**-**	145	-
NHS South Kent Coast CCG	**717**	**-**	642	-
NHS Surrey Downs CCG	**985**	**-**	893	-
NHS Swale CCG	**948**	**-**	949	-
NHS Thanet CCG	**420**	**-**	358	-
NHS West Kent CCG	**5,598**	**-**	5,746	-
HM Revenue & Customs (apprenticeship levy and Employer NI contributions)	**-**	**4,118**	-	4,001
NHS Pension Scheme (Employer contributions)	**-**	**6,492**	-	4,210
	65,903	**15,434**	64,525	13,077

22. Related Party Transactions (cont.)

Receivables and payables	31 March 2020		31 March 2019	
	Receivables	**Payables**	Receivables	Payables
	£000	**£000**	£000	£000
Brighton and Sussex University Hospitals NHS Trust	**935**	**632**	757	1,120
Guy's & St Thomas' NHS Foundation Trust	**10**	**27**	106	12
Maidstone and Tunbridge Wells NHS Trust	**121**	**76**	83	76
Dartford and Gravesham NHS Trust	**7**	**779**	7	512
Medway NHS Foundation Trust	**6**	**1,122**	89	546
East Sussex Healthcare NHS Trust	**-**	**705**	-	490
Sussex Community NHS Foundation Trust	**40**	**2**	131	-
Surrey And Sussex Healthcare NHS Trust	**336**	**81**	349	112
East Kent Hospitals University NHS Foundation Trust	**1**	**60**	-	51
Northumbria Healthcare NHS Foundation Trust	**-**	**101**	-	33
NHS Resolution (formerly NHS Litigation Authority)	**-**	**-**	-	-
Care Quality Commission	**-**	**-**	-	-
Health Education England	**630**	**-**	493	-
NHS England	**2,159**	**-**	2,752	8
NHS Ashford CCG	**6**	**-**	25	-
NHS Bexley CCG	**-**	**-**	-	105
NHS Brighton and Hove CCG	**11**	**-**	-	32
NHS Bromley CCG	**-**	**-**	-	13
NHS Canterbury and Coastal CCG	**16**	**-**	-	15
NHS Coastal West Sussex CCG	**369**	**-**	333	-
NHS Crawley CCG	**34**	**-**	29	-
NHS Croydon CCG	**-**	**-**	-	42
NHS Dartford, Gravesham and Swanley CCG	**-**	**-**	-	82
NHS East Surrey CCG	**48**	**-**	-	335
NHS Eastbourne, Hailsham and Seaford CCG	**-**	**-**	-	87
NHS Guildford and Waverley CCG	**17**	**-**	56	-
NHS Hastings and Rother CCG	**21**	**-**	56	-
NHS High Weald Lewes Havens CCG	**141**	**9**	-	41
NHS Horsham and Mid Sussex CCG	**169**	**-**	224	-
NHS Medway CCG	**-**	**-**	-	63
NHS North West Surrey CCG	**144**	**-**	72	-
NHS South Kent Coast CCG	**53**	**-**	59	-
NHS Surrey Downs CCG	**70**	**-**	83	-
NHS Swale CCG	**-**	**-**	60	-
NHS Thanet CCG	**-**	**-**	2	76
NHS West Kent CCG	**-**	**-**	-	220
HM Revenue & Customs (apprenticeship levy and NI contributions)	**-**	**1,113**	-	1,063
NHS Pension Scheme	**-**	**652**	-	713
	5,344	**5,359**	5,766	5,847

23. Intra-Government and Other Balances

Receivables: amounts falling due within one year

	31 March 2020 £000	31 March 2019 £000
Balances with NHS bodies	**6,548**	7,780
Balances with other government bodies	**615**	247
Balances with bodies external to government	**2,621**	2,936
Provision for the impairment of receivables	**(1,241)**	(753)
	8,543	10,210

Payables: amounts falling due within one year

	31 March 2020 £000	31 March 2019 £000
Balances with NHS bodies	**3,772**	4,156
Balances with other government bodies	**1,791**	2,090
Balances with bodies external to government	**6,229**	5,966
	11,792	12,212

24. Losses and Special Payments

Losses and special payments are calculated on an accruals basis.

There were 20 cases of losses and special payments totalling £7,000 during 2019/20, (29 cases totalling £6,000 in 2018/19).

All cases are reported on an accruals basis and do not include provisions for future losses.

There were no fraud cases within these losses.

Losses and Special Payments	**31 March 2020**	31 March 2019

	No.	£000	No.	£000
Losses - Bad Debts and claims abandoned	**-**	**-**	11	1
Losses - Fruitless payments and constructive losses	**1**	**4**	-	-
Losses - Stores Losses	**-**	**-**	-	-
Special Payments - Ex gratia payments	**19**	**3**	18	5
	20	**7**	29	6

25. Third party assets

The Trust holds minimal levels of third party assets, usually related to patients' monies.

7 APPENDICES

7.1 Board of directors register

*Non-voting

Name, title and appointment	Meeting attendance and role 2019/20						
	Board of Directors	**Audit committee**	**Nomination & remuneration committee**	**Finance & performance committee**	**Quality & governance committee**	**Council of governors**	**QVH Charity**
Keith Altman Medical director 1 October 2019 to 30 September 2022	2 of 3 (member)	NA	NA	NA	2 of 3 (member)	2 of 2 (attendee)	1 of 1 (member)
Ginny Colwell Non-executive director 21 April 2016 to 20 April 2019	NA	NA	NA	NA	1 of 1 (chair to 20/04/19)	1 of 1 (attendee)	NA
Paul Dillon-Robinson Non-executive director 1 October 2019 to 30 September 2022	3 of 3 (member)	2 of 2 (member)	1 of 1 (member)	6 of 6 (chair from 01/10/19)	NA	2 of 2 (attendee)	NA
Kevin Gould Non-executive director 1 September 2017 to 30 August 2020	6 of 6 (member)	5 of 5 (chair)	1 of 1 (member)	12 of 12 (member)	NA	3 of 4 (attendee)	NA
Beryl Hobson Chair 1 April 2018 to 31 March 2021	6 of 6 (chair)	NA	1 of 1 (chair)	8 of 12 (member)	NA	4 of 4 (member)	2 of 3 (member)
Steve Jenkin Chief executive 14 November 2016 to present	6 of 6 (member)	NA	1 of 1 (member)	10 of 12 (member)	4 of 7 (member)	4 of 4 (attendee)	NA
Abigail Jago * Director of operations 8 May 2018 to present	6 of 6 (member)	NA	NA	9 of 12 (member)	3 of 7 (member)	3 of 4 (attendee)	NA

Gary Needle Non-executive director 1 July 2017 to 30 June 2020, and senior independent director since 1 October 2019	6 of 6 (member)	NA	0 of 1 (member)	NA	4 of 7 (member)	4 of 4 (attendee)	3 of 3 (chair)
Michelle Miles Director of finance and performance 1 February 2018 to present	5 of 6 (member)	NA	NA	11 of 12 (member)	5 of 7 (member)	3 of 4 (attendee)	1 of 3 (member)
Karen Norman Non-executive director 8 April 2019 to 7 April 2022	6 of 6 (member)	4 of 5 (member)	0 of 1 (member)	NA	6 of 6 (chair from 21/04/19))	3 of 3 (attendee)	NA
Geraldine Opreshko * Director of workforce and organisational development 26 July 2017 to present	5 of 6 (member)	NA	1 of 1 (attendee)	9 of 12 (member)	5 of 7 (member)	2 of 4 (attendee)	NA
Lucy Owens Interim director of finance and performance 3 February 2020 to 26 March 2020	1 of 1 (member)	NA	NA	2 of 2 (member)	0 of 1 (member)	NA	NA
Ed Pickles Medical Director 1 October 2016 to 30 September 2019	3 of 3 (member)	NA	NA	NA	3 of 4 (member)	1 of 2 (attendee)	2 of 2 (member)
Clare Pirie * Director of communications and corporate affairs 1 May 2017 to present	6 of 6 (member)	NA	0 of 1 (attendee)	NA	NA	3 of 4 (attendee)	NA
Jo Thomas Director of nursing and quality 1 February 2015 to present	5 of 5 (member)	NA	NA	NA	6 of 7 (member)	4 of 4 (attendee)	NA
John Thornton Non-executive director 1 October 2013 to 30 September 2019	3 of 3 (member)	3 of 3 (member)	0 of 0 (member)	7 of 7 (chair to 30/09/19)	NA	2 of 2 (attendee)	NA

7.2 Council of governors register 2019/20

Name	Constituency	Status of current term	Start of term	End of term	Meeting attendance
Beesley, Brian	Public	Elected 1st term	01/07/2018	30/06/2021	4 of 4
Belsey, John[1]	Public	Re-elected 2nd term	01/07/2017	30/06/2020	2 of 4
Bennett, Liz	Stakeholder[2]	Appointed	01/07/2013	30/06/2018	3 of 4
Brown, St John	Stakeholder[3]	Appointed	01/04/2017	31/03/2020	3 of 4
Burkhill-Prior, Wendy	Public	Elected 1st term	01/07/2016	30/06/2019	0 of 1
Dudgeon, Robert	Public	Re-elected 2nd term	01/07/2016	30/06/2019	1 of 1
Fry, Colin	Public	Elected 1st term	01/07/2018	30/06/2021	3 of 4
Fulford-Smith, Antony	Public	Elected 1st term	01/07/2017	30/06/2020	3 of 4
Glynn, Angela	Public	Re-elected 2nd term	01/07/2017	30/06/2020	1 of 4
Haite, Janet	Public	Elected 1st term	01/07/2017	30/06/2020	3 of 4
Halloway, Chris	Public	Re-elected 2nd term	01/07/2018	30/06/2021	4 of 4
Harold, John	Public	Elected 1st term	01/07/2019	30/06/2022	3 of 3
Holden, Julie	Stakeholder[4]	Appointed 1st term	06/01/2020	05/01/2023	0 of 1
Hunt, Douglas	Public	Elected 1st term	01/07/2017	30/06/2020	3 of 4
Lane, Andrew	Public	Elected 1st term	01/07/2018	30/06/2021	4 of 4
Lehan, Carol	Staff	Elected 1st term	01/07/2017	30/06/2020	4 of 4
Lockyer, Sandra	Staff	Elected 1st term	01/07/2017	30/06/2020	2 of 4
McGarry, Joe	Public	Elected 1st term	01/07/2017	30/06/2020	1 of 4
Martin, Tony	Public	Re-elected 2nd term	01/07/2017	30/06/2020	4 of 4
Roche, Glynn	Public	Re-elected 2nd term	01/07/2017	30/06/2020	3 of 4
Shore, Peter[5]	Public	Elected 1st term	01/07/2016	30/06/2019	4 of 4
Tamplin, Robert	Public	Elected 1st term	01/07/2017	30/06/2020	4 of 4
Tappenden, Tony	Public	Elected 1st term	01/07/2017	30/06/2020	2 of 4
Webster, Norman	Stakeholder[6]	Appointed	01/07/2011	05/05/19	1 of 1
Wiggins, John	Public	Elected 1st term	01/07/2017	30/06/2020	2 of 4
Williams, Martin	Public	Elected 1st term	01/07/2018	30/06/2021	4 of 4
Wilson, Mickola	Public	Elected 1st term	01/07/2017	30/06/2020	3 of 4

[1] Nominated Lead Governor to July 2019
[2] Representing West Sussex County Council
[3] Representing QVH League of Friends
[4] Representing East Grinstead Town Council from January 2020
[5] Nominated Lead Governor from August 2019
[6] Representing East Grinstead Town Council to May 2019

7.3 Directors' biographies 2019/20

Keith Altman, Medical Director
Keith graduated in both dentistry and medicine from King's College Hospital, University of London and holds an Award in Medical Leadership (2012) and Diploma of Legal Medicine (2014). He undertook his specialty training at Queen Mary's Hospital, Roehampton and The Royal Surrey County Hospital, Guildford. Keith was appointed as Consultant Maxillofacial Surgeon to Brighton and Sussex University Hospitals NHS Trust in 1997 and was Deputy Medical Director and Lead for Revalidation and Appraisal 2013-17. He was appointed at QVH in 2017 and became Medical Director in October 2019.

Ginny Colwell, Non-Executive Director
Ginny 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. Ginny then became corporate head of nursing for Nuffield Hospitals before being appointed head of nursing for Surrey and Sussex Strategic Health Authority. She has also been a founder non-executive director at Central Surrey Health, acting as chair for her last three months, and vice chair of Phyllis Tuckwell Hospice. Ginny worked independently as an individual and organisational coach and as a board advisor to Richmond and Hounslow Community Trust. Ginny joined QVH in April 2016 and stepped down from the Trust at the end of April 2019.

Paul Dillon-Robinson, Non-Executive Director
Paul joined the board in October 2019. Paul, from Buxted near Uckfield, is a Chartered Accountant who spent 17 years working in the NHS as a head of internal audit for a range of organisations in the Kent, Sussex and Surrey area. He then spent nine years as Director of Internal Audit for the House of Commons. Paul currently combines tutoring, training and consultancy work with non-executive and charity roles. At QVH, Paul chairs the finance and performance committee and is a member of the audit committee.

Kevin Gould, Non-Executive Director
Kevin joined the board in September 2017. He is a Chartered Accountant with more than 25 years' experience in the financial services and consulting industries, focussing on governance, risk and audit. Kevin has lived in Sharpthone (a village in Mid Sussex), where he is a parish councillor, since 1998, and is involved in a number of commercial and charitable organisations as a consultant and non-executive director. At QVH, Kevin chairs the audit committee and is a member of the finance and performance committee.

Beryl Hobson, Chair
Beryl joined QVH in July 2014 as a non-executive director and chair designate, before becoming chair in April 2015. She is the executive director of a governance consultancy and was previously chair of the NCT (National Childbirth Trust). Beryl was the first chair of Sussex Downs and Weald Primary Care Trust and has more than 20 years of board level experience gained in private, charity and NHS organisations. On 1 April 2018, Beryl was reappointed for a second term.

Steve Jenkin, Chief Executive
Steve Jenkin joined the Trust in November 2016. He was previously the chief executive of Peninsula Community Health, providing services across Cornwall and the Isles of Scilly including running 14 community hospitals. Prior to that Steve was director of health and social care with national charity Sue Ryder, and chief executive

of Elizabeth FitzRoy Support, a national charity supporting people with learning disabilities. Steve has an MBA through the Open University.

Abigail Jago, Director of Operations (non-voting)
Abigail Jago joined the Trust in May 2018 from Barts Health NHS Trust and has a wealth of experience in a range of senior operational, programme and strategic hospital roles. Since joining the NHS in 2000, she has managed services across multiple sites and has led change programmes in both an acute setting and across health and social care systems. Abigail is passionate about the NHS and the delivery of system wide improvement.

Michelle Miles, Director of Finance and Performance
Michelle was appointed in February 2018 from Croydon Health Services NHS Trust where she was deputy director of finance. Michelle has worked in the NHS for 20 years, having begun her career as a band 3 management accountant. She has a strong community background, having previously worked in community and primary care trusts. In 2009, Michelle moved to South London to take up her first role in an acute trust, an area of the NHS where she has remained. Michelle is particularly interested in understanding how finance professionals can support the delivery of excellent patient care and outcomes and all staff can help reduce wastage and improve efficiency.

Gary Needle, Non-Executive Director/Senior Independent Director
Gary Needle joined the board in July 2017. He has over 35 years' experience in health care executive management including posts as a chief executive in Brighton and Hove and as a director at the national quality inspectorate. He spent seven years in Qatar, where he was director of planning for the national health care system. Gary is chair of the board of trustees at East Grinstead Sports Club Ltd. At QVH, Gary chairs the charity committee and sits on the quality and governance committee; he assumed the role of senior independent director in October 2019.

Karen Norman, Non-Executive Director
Karen joined the board in April 2019 and chairs the Quality and Governance Committee. She has worked in healthcare for 40 years in both the public and private sectors in the UK, Australia, New Zealand and Gibraltar. She has 20 years' experience as an executive director at board level, as Gibraltar's chief nursing officer, and was director of nursing and clinical governance at Brighton and Sussex University Hospitals NHS Trust from 1993 to 2004. Karen has also worked as a management consultant for Crosby Associates, an American quality management company. She currently works as visiting professor, faculty member and research supervisor on the Doctorate in Management Programme at the University of Hertfordshire, and also as visiting professor at Kingston University and St George's, University of London, in the School of Nursing.

Geraldine Opreshko, Director of Workforce and Organisational Development (non-voting)
Geraldine has worked across health and social care since 1994, and holds an MSc in People and Organisational Development. She has held board level positions in the NHS since 2004 covering workforce, organisational development and transformation. Geraldine has worked across the East and South East of England including Bedfordshire, Norfolk, Cambridge and Kent in acute and community settings before joining QVH in May 2016.

Dr Edward Pickles, Medical Director
Ed, a consultant anaesthetist at QVH since 2006, was appointed to the role of medical director in October 2016. He qualified in medicine from the University of Dundee, and then trained in anaesthesia in Yorkshire and London, including QVH, King's College Hospital and Great Ormond Street. His clinical interests include paediatric anaesthesia, and anaesthesia for head and neck surgery. Prior to becoming medical director, Ed was training programme director for anaesthetic trainee support in the Kent Surrey Sussex Deanery, and director of medical education and clinical director for clinical audit and outcome measurement here at QVH. Ed stepped down from the medical director role in September 2019.

Clare Pirie, Director of Communications and Corporate Affairs (non-voting)
Clare joined QVH in 2016. She has been supporting clear communication in the NHS since 2000, working at King's College Hospital and Brighton and Sussex University Hospitals, as well as for national and local NHS commissioning organisations. Clare's role at QVH includes corporate governance and development of the QVH Charity, as well as strategic leadership for communications and engagement.

Jo Thomas, Director of Nursing and Quality
Jo was appointed in June 2015 having previously held the post in an interim capacity since February 2015. Before joining QVH, Jo held chief nurse positions in both commissioning and acute provider organisations. Jo began her NHS career as a nursing auxiliary before commencing her training in Brighton. She has 35 years of nursing experience in elective, specialist and emergency care, with a specialist interest and an MSc in women's health. Jo has senior management experience of leading and managing specialist services as well as extensive involvement in operational delivery and the redesign of health care services.

John Thornton, Non-Executive Director/Senior Independent Director
John has almost 30 years' experience as a senior executive in the financial services industry. He is involved in a range of business and community activities as a consultant, non-executive director and mentor. At QVH John chaired the finance and performance committee and was a member of the audit committee. He stepped down from his role at QVH in September 2019.

Queen Victoria Hospital is a specialist NHS hospital providing life-changing reconstructive surgery, burns care and rehabilitation services, primarily in the South of England.

We are a centre of excellence, with an international reputation for pioneering complex surgical techniques and treatments.

Our world-leading surgeons perform routine reconstructive surgery for the people of East Grinstead and surrounding areas, specifically for hands, eyes, skin and teeth, and are supported by therapy teams who are highly trained in the management of complex and high-risk trauma, disease and disfigurement.

The hospital also provides a minor injuries unit, expert rehabilitation services and a sleep service.

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. You can find out more at qvh.nhs.uk

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