Queen Victoria Hospital
NHS Foundation Trust

QUEEN VICTORIA HOSPITAL
NHS FOUNDATION TRUST

Annual Report and Accounts 2021/22

QUEEN VICTORIA HOSPITAL
NHS FOUNDATION TRUST

Annual Report and Accounts 2021/22

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

CONTENTS

1 Introduction

Chair's introduction

It is vital that the future of the outstanding services provided by Queen Victoria Hospital (QVH) are secure, together with the internationally-acclaimed innovation and research which ensures continuing development of the services so highly valued by patients. Back office support roles may be less visible than clinical roles but at QVH the dedicated people delivering the firm foundation of robust financial management, good governance, operational management and workforce support exceed reasonable expectations; the teams are small and give proportionately more of their time and shoulder more in terms of responsibility. National funding arrangements during the pandemic have meant that the worsening underlying financial deficit has been temporarily obscured but analysis reveals that the costs of this small trust will continue to exceed income and that simple efficiency savings cannot close the gap.

Looking forward, I believe there are real opportunities for further development of both specialist and local clinical services at QVH with targeted investment and support. Identifying, and delivering on, those opportunities for the benefit of patients, staff and the wider communities served by QVH is core and ongoing work for our Board. The Independent Review of QVH's handling of challenges encountered in progressing a merger proposal with University Hospitals Sussex NHS Foundation Trust was welcomed by the Trust Board. The Board is committed to ensuring that the recommendations are implemented effectively, with ongoing engagement and an inclusive approach with staff and external stakeholders. There is much more work to be done to ensure that the hopes and concerns of our local community, our staff, and our patients are heard, and that the reasons why the Board are considering a possible merger are clearly understood.

The former Chair, Beryl Hobson, said farewell in September 2021 after serving seven years at the Trust. She joined as a non-executive director and Chair designate in 2014 and took up the position of Chair from 2015.

I shall be passing over to a new Chair in July 2022, and I want to say thank you to everyone who I have worked with over my eight month tenure as interim Chair. I have heard a wide range of views expressed during my time here, often strongly-held, and occasionally opposing, but commitment and devotion to this outstanding small trust have shone through. Passions run high about QVH because it provides nationally and internationally-renowned services, and because people are proud to work at a hospital known for kind and compassionate care. I have every confidence that QVH has a positive future, where the hospital on this site, and the clinical excellence and outstanding patient care that it provides, are secure.

Anita Donley
Chair
15 June 2022

2 Performance

Overview of performance

Statement from the chief executive

This annual report is a record of the work of the hospital through the second year of the pandemic.

It is a year in which we have settled into some new ways of working; the environmental benefits of virtual appointments are evident in a trust which serves a wide area and, while we closely monitor patient feedback to make sure we are getting it right, removing the need for long journeys for short check-ups that can be done by phone or video is a real benefit for many patients.

It is a year in which we have had to maintain high levels of infection control to protect our patients and staff. At the time of writing, we are still asking everybody coming on site to wear a face mask, and we are acutely aware of the correlation between staff absence and our ability to maintain our patient services.

It is also a year to be proud of our contribution to the care of cancer patients and others needing our life changing services. In the winter of 2021/22 QVH again stepped up as a specialist surgical cancer hub. This enabled cancer patients from other hospitals who otherwise would have serious delays in the surgery they needed to come to QVH with their surgeon. The QVH theatre and ward teams supported the visiting surgeons and the patients, ensuring cancer patients received vital surgery at this difficult time. Alongside this we also maintained a year long record of meeting the 62 day cancer standard for patients referred to QVH. That means all our cancer patients had a confirmed diagnosis and started treatment within 62 days; a stand out success against the national picture of the majority of trusts struggling to achieve this in challenging circumstances.

2021/22 was also a year in which we initiated two key areas of investment which will continue to develop in the year ahead.

As an early adopter of the national initiative to establish community diagnostic centres outside of mainstream acute hospitals, QVH is providing swift access to diagnostics for patients referred from local practices, and we hope to serve an increasing number of GP practices in the year ahead. Prompt diagnosis means patients can start the right treatment straight away, and it also takes pressure off accident and emergency services elsewhere.

Investment on site in two new theatres will also bring benefits for patients and for the wider healthcare system. The new theatres are a modular build replacing two old theatres and will be suitable for a wider range of surgery; with this greater flexibility over case mix, together with modern air flow and temperature control, we expect to be able to significantly increase the number of operations we can carry out each month. This will provide a real boost for our work and for patient care at a time when addressing post-pandemic waiting lists is essential.

Throughout the year we have seen consistently positive feedback across our services with 99% of inpatient respondents likely or very likely to recommend us to friends and family. The CQC adult inpatient survey rated us as the highest in the country and the children and young person survey also rated the trust highly for positive patient experience.

I hope what also shines out through the pages of this annual report is that it is our people who make QVH a much loved and highly regarded hospital. I would like to put on record my thanks to our staff and volunteers for all that they do to make sure our work reflects our values of humanity, pride and continuous improvement, and that QVH remains a good place to work and a truly exceptional place to receive treatment.

Steve Jenkin
Chief Executive and Accounting Officer
15 June 2022

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 2021/22, the principal activities of the Trust were the provision of:

- plastic surgery (including reconstructive surgery for cancer patients) and burns care
- corneoplastic surgery
- 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:

- University Hospitals Sussex NHS Foundation 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 2021/22, when the pandemic impacted on the ability of other Trusts to maintain cancer surgery, patients from other hospitals in the south east were able to receive their cancer surgery at QVH with surgeons from other trusts operating at QVH alongside our expert theatre teams.

A brief history of the foundation trust and its statutory background
QVH was authorised as one of the country's first NHS foundation trusts in July 2004. A foundation trust is a public benefit corporation providing NHS services in line with the core NHS principles: that care should be universal, comprehensive and free at the point of need. The Trust is licensed as a foundation trust to provide these services by the independent regulator; NHS England and NHS Improvement. The specialist services that the Trust provides are regulated by the Care Quality Commission.

As a foundation trust, we are accountable to local people through our public members across Kent, Surrey, Sussex and the boroughs of South London.

The Trust is corporate trustee to the Queen Victoria Hospital NHS Trust Charitable Fund. The charitable fund was first registered with the Charity Commission in 1996, registration number 1056120. As corporate trustee, the Trust is responsible for controlling the work, management and administration of the charity on behalf of its beneficiaries who are itself, its patients and its staff.

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 been working for a number of years on strategic plans to secure the long term future of the hospital in the context of challenges related to being the smallest acute trust in the country. This work has involved engagement of stakeholders throughout, particularly staff and governors, as well as external stakeholders such as MPs and councils.

In August 2021 the Boards of QVH and University Hospitals Sussex NHS Foundation Trust (UHSussex) agreed to work together to develop a full business case for potential merger. This will involve detailed work to explore the operational, clinical and financial aspects of a potential merger; which will provide the information needed for the Boards of both organisations to determine whether to proceed with the merger process. The pandemic and operational pressures impacted our ability to progress the work in the later part of the year; we continued to respond to stakeholders who had questions about the possible merger explaining the case for change and the intention to begin further work in 2022/23.

In December 2021, NHS England and NHS Improvement South East Region and the interim Chair of QVH, Anita Donley, commissioned an independent review of QVH's handling of challenges encountered in progressing a merger proposal with University Hospitals Sussex NHS Foundation Trust, given the range of views about the future of QVH. In February 2022 the report was published in full on the QVH website. The Board is committed to ensuring the recommendations are acted on effectively, with good ongoing engagement with staff and external stakeholders.

The Trust has developed its strategic emphasis across five key strategic objectives. These are set out below and include details of the principal 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.

During 2021/22 the principal risk has continued to be delivering outstanding patient experience during the Covid-19 pandemic. The new clinical pathways continue to maintain patient safety and point of care testing for staff and patients continues to ensure rapid identification of Covid-19 infection. Alongside preoperative screening and support, this has enabled QVH to safely function as a cancer hub for the region.

The CQC adult inpatient survey rated us as the highest in the country and the children and young person survey also rated the trust highly for positive patient experience.

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.

Changes to pathways and collaboration with the wider NHS system have enabled QVH to function as a cancer hub throughout the pandemic. This extra activity has impacted on more routine clinical work; we have introduced, and continue to operate, additional clinical review processes for patients waiting for surgery to balance the risks of Covid-19 and non-Covid harm.

We have embraced new technologies and adapted our working practices, including virtual service provision and one-stop pathways to reduce the need for multiple visits to the site.

There continue to be clinical services that have staffing challenges, especially in smaller teams, and this has been a greater risk over the last year with the frequent need for staff to undertake periods of isolation. This has been mitigated to some extent with new ways of working, in particular virtual clinics.

Although the teams have worked under considerable pressure, research and innovative practice continues at QVH, with publications evidencing our high quality outcomes.

3. Operational excellence
We provide services that ensure patients are offered choice and are treated in a timely manner ensuring patient receive optimal pathways.

The principal risks to delivery of this objective are the continued significant waiting list backlogs due to covid as well as the availability and capacity of specialist clinical staff across our sites and available theatre capacity. QVH stepped up as a specialist surgical cancer hub supporting breast, skin, head and neck oncology services across Kent, Surrey and Sussex during the pandemic. This provided vital surgery for cancer patients but also had an impact on QVH-specific waiting lists.

The Trust is working collaboratively with other providers to support waiting times across the NHS locally and identify strategic opportunities to benefit patients across the region. The development of the Community Diagnostic Centre at QVH will increase local provision as well as opportunities for QVH to support patients from further afield with prompt diagnostics and physiological testing.

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

The Covid-19 financial regime for the NHS through 2021/22 meant providers remained on a block contract framework. NHS organisations were required to submit two plans for

2021/22, one that covered H1 (months 1-6) and one for H2 (months 7-12). The Trust worked with the wider system to establish a breakeven budget for H1, which included an efficiency target of £800k for the Trust. This was approved by the Trust Board in June 2021, in line with revised national planning timetables.

While Trust was able to deliver its financial obligations for 2021/22 in year, a material underlying deficit remains.

Following the cessation of the Covid-19 financing regime, the Trust will receive 'top up funding' for 2022/23. The run rate for the Trust has remained stable, with expenditure exceeding income before 'top up'. The top up funding is designed to support the Trust to balance, but the increased levels of inflation now being experienced are not contained within this new funding regime.

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.

Despite the significant operational challenges that we have been faced with, we have maintained, and in some areas slightly improved, performance against key indicators for this objective. We continue to support staff with working more flexibly and ensuring the highest standards of infection control are maintained to ensure staff are protected. We have continued to recruit staff from overseas and benefit from a richer diversity amongst our workforce. Bank and agency usage remained stable and did not return to pre-covid levels in-year. Our staff education and learning offers were re-designed for virtual delivery and there was an increased take up of e-learning for mandatory and statutory training. Staff survey scores have remained stable with an increase in the overall response rate as described elsewhere in this report.

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

The Trust when preparing financial statements is required under International Accounting Standard 1 to undertake an assessment of the Trust's ability to continue as a going concern. Due to the materiality of the financial position, 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. In keeping with a number of other NHS trusts working in the current financial regime, the Trust is assured of access via NHS England and Improvement to financial resources to support the financial position.

There is no prospect that within the next 12 months, or the foreseeable future, health services will cease to be provided from the Queen Victoria Hospital site. At present the Trust is investigating a potential merger; if the merger progresses within 12 months from the date of signing the accounts this would not impact on the Trust's going concern status as its services would continue to be provided within the public sector.

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 integrated care system (ICS) and 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. 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

Analysis and explanation of development and performance

Care quality
The CQC relationship manager meets virtually with the Trust on a regular basis.

During Q4 the Trust recommenced the internal inspection and improvement process known as 'compliance in practice' with visits to clinical areas. Quality is continually monitored by the clinical governance group and the quality and governance sub-committee of the board, and a range of quality metrics are discussed at board level. The Trust is fully compliant with the registration requirements of the CQC. The overall rating for the hospital remains as 'good' with a rating of 'outstanding' for care as per the CQC inspection of 2019.

Infection control
QVH had 1 hospital acquired case of Clostridium difficile, 0 E. Coli bacteraemia, 3 MSSA bacteraemia and 0 hospital acquired MRSA bacteraemia in 2021/22.

There were three hospital acquired cases of Covid-19.

There were two Covid-19 outbreaks; an outbreak is two or more test-confirmed cases of Covid-19 among individuals associated with a specific non-residential setting with illness onset dates within 14 days. There was no impact from this on patient care or experience.

Waiting times
In 2021/22 waiting times continued to be severely impacted by the Covid-19 pandemic. QVH stepped up as a specialist surgical cancer hub supporting breast, skin, head and neck oncology services across Kent, Surrey and Sussex during the pandemic; this provided vital surgery for cancer patients but also had an impact on QVH-specific waiting lists.

The total number of patients waiting longer than one year for treatment increased substantially in the first year of the pandemic as capacity was utilised for the management of cancer and other patients prioritised for their clinical need. While numbers reduced in 2021/22 they remain very high.

All the patients on the waiting list have been assessed for clinical priority and this information is used to manage the scheduling.

	Q1	Q2	Q3	Q4
Patients waiting longer than 52 weeks	414	245	233	215
Referral to treatment within 18 weeks (target 92%)	75.30%	72.00%	65.20%	64.36%
Total waiting list size	10,839	11,080	11,414	12,639

Figures shown are month end for each quarter

Cancer waiting times

During 2021/22 QVH continued to improve waiting times for cancer patients. The Trust has made good progress in delivering the new faster diagnosis standard and sustained performance delivery on the 62 day standard.

The number of late referrals received by the Trust and the increase in complexity of cases made achieving the trajectory set out for the 62 day and 104 day waits challenging.

The two-week wait standard (maximum time from urgent GP referral for suspected cancer to first hospital assessment) fell in quarter one due to the need for patients to self-isolate in advance of treatment but has recovered well throughout the remainder of the year.

Patients with cancer are prioritised using our validation system and this feeds into the clinical harm review process if there are delays.

	Q1	Q2	Q3	Q4
Patients beginning first definitive treatment within 62 days following urgent GP referral for suspected cancer	88.6%	90.6%	86.3%	92.8%
31 day decision to treat	96.9%	96.1%	95.1%	95.8%
Two week wait referral for suspected cancer	97.7%	90%	91.9%	92.5%
Faster diagnosis standard (Shadow monitoring)	86.3%	83.3%	84.6%	84.4%

Figures shown are month end for each quarter

Equality of service delivery to different groups

All Trust policies are subject to an equality impact assessment to ensure no adverse impact on patients or staff with protected characteristics. In line with the public sector equality duty, the Trust also works to reduce or remove the disadvantage suffered by people because of a protected characteristic. For example, ensuring alternative pathways for patients with learning difficulties or dementia who often cannot tolerate a nose and throat Covid-19 swab. We review patient feedback in both the national friends and family

test and the annual national inpatient survey by gender, age, disability and ethnicity, checking for any emerging issues requiring action. Work continues to increase the comprehensiveness of information on patients' protected characteristics, including ethnicity coding, in order to monitor equality of access.

The Trust has improved its reporting on health inequalities especially in relation to cancer. A monthly report is produced and presented at the Trust's Cancer Board, focusing on deprivation, age, gender and ethnicity, looking at patient cancellations, non-attendances and diagnosis to ascertain if any trends can be identified and an action plan produced to monitor improvement. This information is shared across primary care within the Sussex system. Similar reporting has also started for long waiting patients on non-cancer pathways.

Financial plan
The funding regime remained with providers on a block contract framework. NHS organisations were required to submit two plans for 2021/22, one that covered H1 (months 1-6) and one for H2 (months 7-12). The Trust worked with the wider system to establish a breakeven budget for H1, which included an efficiency (cost improvement plan CIP) target of £800k for the Trust. This was approved by the Trust Board in June 2021, in line with revised national planning timetables. During month 10, the Trust reforecast its position to a slight surplus of £1.2m post technical adjustments. The achievement for 2021/22 was a surplus of £1.7m.

Key financial indicators
The key financial performance indicators for 2021/22 are detailed in the table below

	Plan £000	**Actual £000**
Reported financial performance	1,200	1,744

The accounts report a surplus of £1,918k which equates to an adjusted surplus on a control total basis of £1,744k, excluding impact of net impairments resulting from valuation of land and buildings £674k; Department of Health and Social Care (DHSC) 'donated' personal protective equipment consumables stock balance £197k; and the net impact of donated income less donated depreciation of £303k.

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.

	2021/22	**2020/21**
	£000	**£000**
Operating income from patient care activities	82,409	70,786
Other operating income	4,582	14,365
Operating expenses	(83,566)	(80,740)
Operating surplus from continuing operations	**3,425**	**4,411**

Land and buildings were revalued as at 31 March 2022 by professionally qualified, Royal Institute of Chartered Surveyors (RICS) registered, valuers Gerald Eve LLP on a desktop basis. For 2021/22 the valuer, in arriving at the 31 March 2022 valuation, applied the following considerations:

- Operational Assets continue to be valued using a Modern Equivalent Asset Valuation (MEA) on an alternative site basis.

- The valuation took account of changes in building cost market values since the full valuation at 31 March 2021.
- The valuer also took note of maintenance and enhancements undertaken by the Trust since the full valuation at 31 March 2021.
- The Trust has entered into an agreement to sell a small parcel of land (approximately 1.5 hectares). As the site is valued on a MEA Alternate site basis, no value has been associated with the land within the 2021/22 accounts.

Income
Total income for the Trust was £87m, an increase of £1.8m on last year due to the change in financial arrangements as a result of the pandemic. The Trust received £82.4m for the provision of patient care activities. The Trust received other operating income of £4.6m, this included £0.2m for centrally allocated personal protective equipment (PPE), £0.9m for top-up support on top of the block payments for 2021/22 and £1.9m from Health Education England to support the cost of providing training and education to medical and other NHS staff. Classification changes in year from 2020/21 for income is mainly due to the top up received by the Trust due to the Covid-19 pandemic.

Operating expenses
The Trust incurred £83.6m of operating expenses in 2021/22. This includes £57m (69% of total operating expenditure) to employ, on average over the year, 995 members of staff.

Operational non-pay expenditure includes supplies and services costs of £13.1m, drug costs of £1.4m, premises costs of £3.8m, depreciation and amortisation of £4.2m, clinical negligence premium of £0.9m.

Capital
The Trust invested in a £7.2m capital programme within the financial year.
Expenditure by asset class as follows:

Asset class	**£000**
Building enhancements	1,166
Assets under construction	3,984
IT	213
Plant and Machinery	658
Intangibles	1,224

Included in the above, £0k relates to charitable donations.

Cash
The Trust has a cash balance of £17.4m, which represents circa 77 days of operating expenditure. The majority of funds are held with the Government Banking Service (GBS).

Revenue Loans converted to Public Dividend Capital (PDC)
Nil loans have been converted to PDC in 2021/22.

Environmental and sustainability report
Care Without Carbon (CWC) is shorthand for a sustainable NHS. It is a simple idea that reflects the Trust's core approach of delivering excellence, and also the Trust's values of humanity, continuous improvement of care and pride, under-pinned by quality.

This is reflected in the Trust's Sustainable Healthcare Principles:

- Healthier lives: Making use of every opportunity to help people to be well, to minimise preventable ill-health, health inequalities and unnecessary treatment, and to support independence and wellbeing.
- Streamlined processes and pathways: Minimising waste and duplication within the Trust and wider health system to ensure delivery of safe and effective care.
- Respecting resources: Where resources are required, prioritising use of treatments, products, technologies, processes and pathways with lover carbon, environmental and health impacts.

Our sustainability principles also align with the Trust's clinical objectives and the improvement of quality, safety and operational standards.

We have recently updated our CWC strategy, set out in the new Green Plan (formerly a Sustainable Development Management Plan) which is line with NHSEI's climate change strategy 'Delivering a Net Zero National Health Service'. The new Green Plan includes targets for the Trust to reach Net Zero Carbon (NZC) by 2040 for its direct emissions, and 2045 for its indirect emissions.

CWC sets out the actions we need to take across all areas of the Trust through the eight elements (detailed below) to ensure a coordinated approach. The eight elements are designed to integrate sustainable thinking and planning into core operational activities, so that they become part of business as usual and key to the way the Trust functions.

Our impact on the environment as a Trust, as well as our performance in 2021-22 against each of the elements of the Green Plan are detailed below.

Our environmental impact

Our environmental impact is measured by our carbon footprint. This is made up from our operations including the energy used to heat our premises; the electricity we consume; the water we use; emissions from Trust owned vehicles and from our business travel or 'grey fleet' mileage which includes the miles driven in staff-owned vehicles.

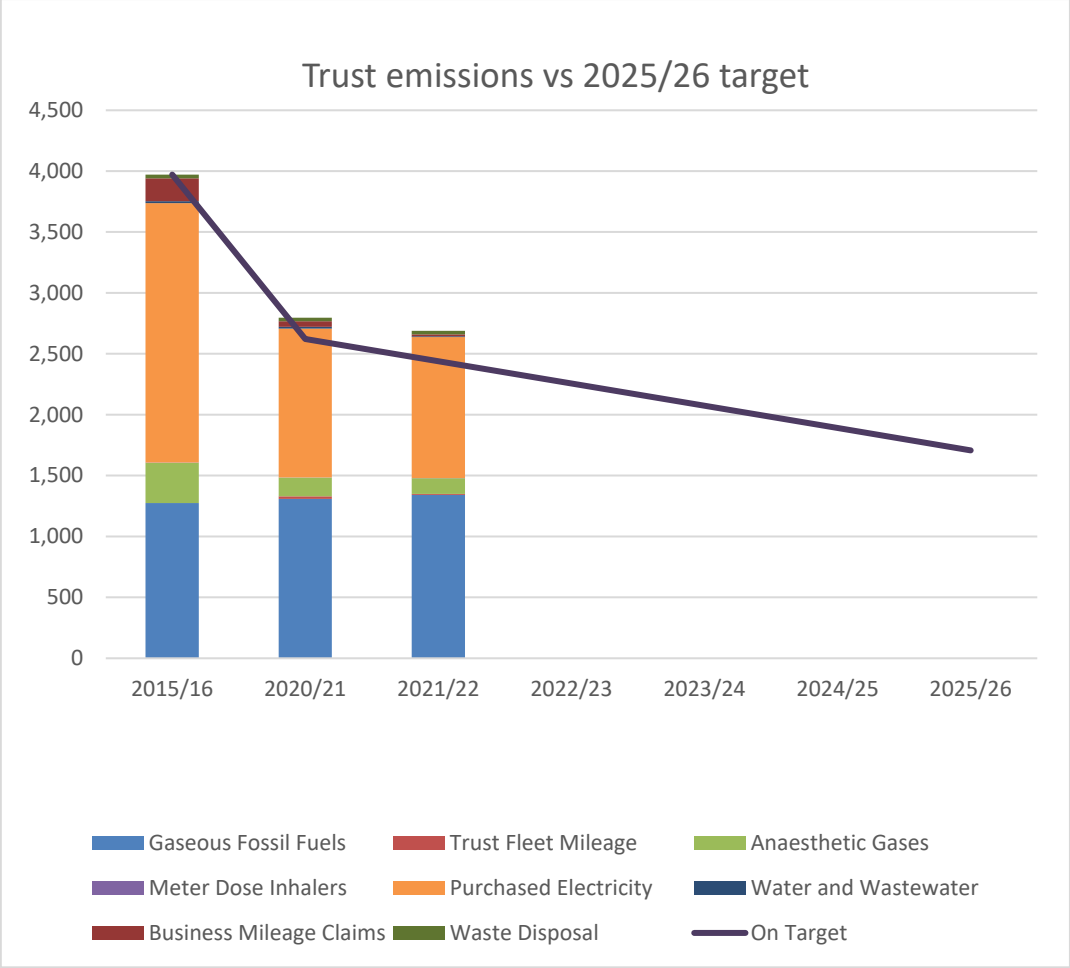


Figure 2: QVH's Carbon emissions against 2025 targets

Emissions Source	2016/17	2021/22
Gaseous fossil fuels	1,274	1,340
Trust fleet mileage	-	8
Anaesthetic gases	330	129
Meter dose inhalers	2	1
Purchased electricity	2,131	1,158
Water and wastewater	16	6
Business mileage claims	187	15
Waste disposal	31	30
TOTAL	3,971	2,689

Figure 3: QVH's carbon footprint

The Trust's absolute annual carbon footprint has reduced by 32% (1,282 tonnes of CO_2e) since the base year in 2015/16. The new Green Plan will support the Trust in meeting its target of a 57% reduction in annual emissions by 2025/26 against its base year emissions.

Governance

The delivery, monitoring and reporting of our sustainability strategy (Green Plan) is supported by Sussex Community NHS Foundation Trust's Sustainability and

Environment Team. The team assists with implementing key aspects of the programme, working alongside teams within in the Trust and feeding into the Trust's Board lead for sustainability, Steve Jenkin, Chief Executive. Leads will also be identified for each action who will be responsible for the management and timely delivery of their actions. Our Green Plan Group will review progress against the actions under each element, provide support to task and finish groups and escalate to board where required.

Key highlights this year

CWC has developed both in terms of its approach and its reach. The new strategy is in its infancy but we can report on progress to date against each of the eight elements.

Places - *Ensuring our places are low carbon and protect local biodiversity whilst supporting wellbeing for staff, patients and visitors.*

Progress for ensuring our buildings and utilities are low carbon includes:

- Continuing to review the Trust's Building Management System, seeking opportunities for carbon reduction.
- Setting up a new electricity supply contract, to commence in 22/23, that ensures all of our electricity is sourced from 100% renewable power generation.
- Continuing the programme to replace existing lighting with low energy and low maintenance LEDs. Phase 2 has been completed and now all key areas are lit with energy efficient lighting providing a 70% energy reduction in lighting energy demand.

Journeys - *Ensuring the transport and travel that links our care and our communities is low cost, low carbon and conducive to good health and wellbeing.*

Progress in reducing the environmental impact of our transport includes:

- The installation across the hospital of more cycle racks and safe storage boxes for those staff and visitors who wish to cycle to the hospital.
- Continued facilitation of video conferencing equipment and training to all staff, enabling virtual meetings both internally between staff and externally with patients, to reduce emissions associated with travel.

Circular economy - *Respecting our health and natural resources by creating an ethical and circular supply chain.*

Progress with circular economy includes:

- Switching to a carbon negative sandwich supplier, cutting the impact of a key area of our catering.
- Ensuring recycling facilities are available across QVH. We now recycle around 30 tonnes each year.
- Continuing our 2018/19 commitment to zero non-healthcare waste to landfill.
- Since 2012 we have been procuring from a central depot, reducing travel required to 1 lorry, 3 times a week.
- Commencing the implementation of unbleached recycled paper across the Trust, with the aim to scale Trust wide next year.

Evolving Care - *Developing and enabling lower carbon and more sustainable models of care.*

Our progress with clinical pathways has focussed on anaesthetics and digital transformation, specifically:

- Significant reducing the impact of our anaesthetic gases. We have a majority TIVA giving anaesthetic department, using intravenous anaesthetic drugs rather than volatile/gas anaesthetics. In addition, the team has removed desflurane vaporisers out of routine access across 10 theatres in 2021.
- Replacing single use anaesthetic trays saving around 2.2 tonnes of carbon dioxide equivalents (tCO2e) and 187,975 litres of water per year.
- Successfully moving to remote care where clinically appropriate, with 25% of our outpatient appointments now conducted remotely. In 2021/22 the Burns Outreach team conducted 54% outpatient appointments remotely, equivalent to saving 16,000km of driving and 2 tonnes of CO2.

Culture – *Empowering and engaging people to create change to progress us towards net zero*.

- In 2021/22 we have established a dedicated section on the staff intranet to provide a link to the Green Plan and other information related to sustainable healthcare.
- We updated our website to share access to the Green Plan with our wider community and stakeholders.
- During the final quarter of 2021/22 we started a piece of research with staff to help benchmark views on sustainable healthcare, including an online survey and one-to-one interviews with staff. This work will progress into 2022/23 and the findings will inform our ongoing engagement approach for our Green Plan.

Wellbeing – *Supporting people to make sustainable choices that enhance their wellbeing.*

QVH staff have created a green outdoor wellbeing space for staff to use to take breaks utilising upcycled office furniture.

Figure 1 a green outdoor wellbeing space created by QVH volunteers

Partnerships and Collaboration - *Enhancing our impact by working with others.*

The core focus for this year has been working with the Care Without Carbon team to develop the first QVH Green Plan. This three year strategy focuses on reducing environmental impact is due to be approved shortly. The next key stage will be finalising the delivery plan, to ensure actions, projects and ambitions outlined in our green plan are supported in the upcoming years.

Climate Adaptation - *Building resilience to our changing climate in Sussex.*

This year we worked on procuring an external provider to undertake a Climate Impact Assessment for Sussex. This will ensure we can assess the potential risks that we face from our changing climate and set out high level actions that we can undertake across our system to further measure and mitigate these risks.

Social and community issues
All Trust policies are subject to an equality impact assessment to ensure no adverse impact on patients or staff with protected characteristics. In line with the public sector equality duty, the Trust also works to reduce or remove the disadvantage suffered by people because of a protected characteristic. For example, ensuring alternative pathways for patients with learning difficulties or dementia who often cannot tolerate a nose and throat Covid-19 swab. We review patient feedback in both the national friends and family test and the annual national inpatient survey by gender, age, disability and ethnicity, checking for any emerging issues requiring action. Work continues to increase the comprehensiveness of information on patients' protected characteristics, including ethnicity coding, in order to monitor equality of access.

The Trust has improved its reporting on health inequalities especially in relation to cancer. A monthly report is produced and presented at the Trust's Cancer Board, focusing on deprivation, age, gender and ethnicity looking at patient cancellations, non-attendances and diagnosis, to ascertain if any trends can be identified and an action plan produced to monitor improvement. This information is shared across primary care within the Sussex system. Similar reporting has also started for long waiting patients on non-cancer pathways.

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**.**

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 covering protection of vulnerable patients at QVH.

The procurement team has reviewed and updated policies and procedures which relate to the Trust's corporate responsibility for slavery and human trafficking. Mandatory questions regarding the Modern Slavery Act 2015 as well as the Bribery Act 2010 are included in new supplier forms and in tender packs.

Where there is concern regarding possible slavery or human trafficking of a patient, to determine appropriate action the patient is seen alone and an independent translator is used, in line with the Trust's safeguarding procedures. If this did not resolve any concerns, then a referral would be made to the police. No cases of slavery or human trafficking were identified in 2021/22.

Overseas operations
QVH has no overseas operations

3 Accountability

3.1 Directors report

Directors' disclosures
In 2021/22 the following individuals served as directors of Queen Victoria Hospital NHS Foundation Trust.

NAME	POSITION
Beryl Hobson	Chair until 30/09/2021 *(voting)*
Anita Donley	Chair from 15/11/2021 (voting)
Paul Dillon-Robinson	Non-executive director *(voting)*
Kevin Gould	Non-executive director *(voting)*
Karen Norman	Non-executive director *(voting)*
Gary Needle	Non-executive director and senior independent director *(voting)*
Steve Jenkin	Chief executive *(voting)*
Michelle Miles	Director of finance and performance *(voting)*
Keith Altman	Medical director until 17/01/2022 *(voting)*
Tania Cubison	Medical director from 18/01/2022 *(voting)*
Nicky Reeves	Director of nursing and quality (interim) until 15/02/2022, chief nurse from 16/02/2022 *(voting)*
Abigail Jago	Director of operations until 20/03/2022 *(non-voting)*
Shane Morrison-McCabe	Director of operations from 21/03/2022 *(non-voting)*
Geraldine Opreshko	Director of workforce and organisational development until 09/06/2021 *(non-voting)*
Lawrence Anderson	Director of workforce and organisational development (interim) from 10/06/2021 *(non-voting)*
Clare Pirie	Director of communications and corporate affairs *(non-voting)*

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 from the 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 2021/22 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 2021/22 compared to 2020/21 is shown below.

Better Payment Practice Code	2021/22 Invoice Quantity	2021/22 Invoice Value £000	2020/21 Invoice Quantity	2020/21 Invoice Value £000
Non NHS				
Total bills paid	17,865	39,589	15,214	36,764
Total bills paid within target	17,000	38,156	13,673	33,720
Percentage of bills paid within target	**95.2%**	**96.4%**	**89.9%**	**91.7%**
NHS				
Total bills paid	1,179	5,933	1,033	5,074
Total bills paid within target	1,080	5,740	754	3,945
Percentage of bills paid within target	**91.6%**	**96.7%**	**73.0%**	**77.7%**

Fees and charges
During 2021/22, the Trust incurred £0k consultancy costs (2020/21 £32k).

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 the annual governance statement below.

Patient care
As in previous years a detailed account of how the Trust delivers and monitors the quality of patient care is included in the quality report which will be available on the Trust's public website. This includes performance against key healthcare targets, arrangements for monitoring national improvements in the quality of healthcare, and patient experience.

Stakeholder relations
During the Covid-19 pandemic QVH has worked in collaboration with providers across Kent, Surrey and Sussex to become a specialist surgical cancer hub. This work used innovative pathways to provide oncology surgical care for patients awaiting breast, head and neck, and skin surgery and associated supportive services.

To support QVH activity as a specialist surgical cancer hub, the Trust has worked closely with the independent sector, particularly Horder Healthcare as its McIndoe Centre is co-located on the QVH site. This relationship initially supported non-elective care for QVH patients, then from August 2020 predominately supported elective activity. This additional capacity has enabled QVH to support the cancer patients at the same time as supporting QVH patient cohorts.

In 2021/22 QVH has been developed as an 'early adopter' Community Diagnostic Centre. The Community Diagnostic Centre model aims to provide care to patients close to home without the need for acute care services. It offers a number of diagnostic and outcome pathways which have been designed using our clinical expertise to support local GPs and primary care partners. This includes a 'breathlessness pathway' with QVH working with a local GP practice to provide specific diagnostics within an established criteria.

We work closely with University Hospitals Sussex 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.

As described earlier in this report, the Trust has been working for a number of years on strategic plans to secure the long term future of the hospital in the context of challenges related to being the smallest acute trust in the country. This work has involved engagement of stakeholders throughout, particularly staff and governors, as well as external stakeholders such as MPs and councillors. More information is provided elsewhere in this report about Board approval of the strategic case in August 2021 and the independent review which reported in February 2022 on QVH's handling of challenges encountered in progressing a merger proposal.

Using feedback to improve services
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:

- National patient surveys – we participate in all relevant national 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 currently receive around 25 PALS contacts and five 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 (more recently virtually) to describe their experience of care at QVH. This 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 websites - we monitor and respond to online sites inviting patient feedback including Care Opinion and the NHS website. This forms an additional 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, Twitter and Instagram 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 and Healthwatch. The group has been involved in work such as improving our food and a programme reviewing the outpatient experience.

Full Friends and Family Test (FFT) data submissions and reporting has been available throughout the 2021/22 financial year. It is acknowledged that the continuing impact of the pandemic has, however, reduced the opportunity for patients to provide FFT feedback face to face or as a written submission, with text messages and telephone surveys becoming more prevalent. Throughout the year we have seen consistently positive feedback across our services. The highlight of the year has been the exceptional

99% of inpatient respondents who are likely or very likely to recommend us to friends and family, with only one inpatient respondent in the entire year unlikely to recommend us.

Steve Jenkin
Chief Executive and Accounting Officer
15 June 2022

3.2 Remuneration report

Annual statement on remuneration

In 2021/22 the very senior management (VSM) pay guidance from NHS Improvement was received in September 2021. The correspondence received from the Chief People Officer for the NHS made clear that Ministers confirmed that there was to be no increase to VSM pay for 2021/22. The guidance did however note that each Trust might from time to time exercise discretion to make exceptional pay awards.

Following receipt of guidance, a meeting of the Trust's nomination and remuneration committee took place and the guidance along with the salaries of the executive directors and chief executive were reviewed. No changes were made to very senior manager (VSM) salaries, however the committee placed on record its recognition for the hard work of the Trust's Executive team.

The committee remained assured that the Trust was in step with comparable benchmarked trusts at the median level.

Anita Donley
Chair of the nominations and remuneration committee
15 June 2022

Very senior managers' remuneration policy
The salary and pension entitlements of very senior managers (VSM) are set out in the section below showing information subject to audit. The QVH approach to remuneration continues to be influenced by national policy, benchmarks 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.

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.

In relation to agreeing and reviewing 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 annual pay award for executive directors is recommended by NHS England and NHS Improvement as described above.

Meetings of the committee during 2021/22 took place virtually.

The director of workforce and organisational development took retirement in June 2021. With the continuing effects of the pandemic and discussions related to the future form of the Trust the chief executive recommended to the remuneration committee that an interim arrangement for an initial 6 month period be considered as there was a natural successor in the deputy director of workforce and an opportunity to develop talent across the wider workforce team. In January 2022 the committee agreed to extend the interim arrangement until June 2022.

The medical director stood down in January 2022. The committee agreed to a full replacement remunerated at the same level as the previous incumbent.

In February 2022 the Trust appointed a permanent chief nurse, and the committee took advice from the specialist team at NHS England and NHS Improvement to provide additional assurance in relation to consistency of terms and conditions.

In March 2022 the director of operations left the Trust and their successor commenced in March 2022. The committee agreed a benchmarked VSM salary, noting that the previous director had also been the accountable officer in the absence of the chief executive, an additional responsibility which the new director would not be expected to take on.

The committee had a further meeting to agree the recommendations of NHS England and NHS Improvement in relation to the annual VSM pay award.

The members of QVH nomination and remuneration committee have 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 less than full 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 appropriate employment agency partner 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 2021/22 the executive management team continued to oversee robust pay and vacancy controls for all roles through weekly virtual 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 were reviewed in 2021/22 in line with clear guidance from NHS England and NHS Improvement, the nomination and remuneration committee approved the recommendations of the guidance and no increases in very senior manager (VSM) pay took place.

Annual report on remuneration
Information not subject to audit

Service contracts

Name	Position	Start date	End Date	Term	Notice period
Steve Jenkin	Chief Executive	14 November 2016		Permanent	6 months
Clare Pirie	Director of Communications and Corporate Affairs	1 May 2017		Permanent	3 months
Michelle Miles	Director of Finance and Performance	1 February 2018		Permanent	3 months
Nicola Reeves	Interim Director of Nursing & Quality	16 November 2020	15 February 2022	15 months	3 months
Nicola Reeves	Chief Nurse	16 February 2022		Permanent	3 Months
Keith Altman	Medical Director	1 October 2019	17 January 2022	Permanent	3 months
Tania Cubison	Medical Director	18 January 2022		Permanent	3 Months
Geraldine Opreshko	Director of Workforce and Organisational Development	26 July 2017	30 June 2021	Permanent	3 months
Lawrence Anderson	Interim Director of Workforce and Organisational Development	10 June 2021		12 Months	3 months
Abigail Jago	Director of Operations	8 May 2018	20 March 2022	Permanent	3 months

Shane Morrison-McCabe	Director of Operations	21 March 2022		Permanent	3 Months

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 four times in 2021/22. All meetings took please on a virtual basis due to the ongoing pandemic. One was a meeting to ratify the recommendations of the chief executive for the interim cover arrangements due to the retirement of the director of workforce and organisational development; a further two reviewed and considered appointment and remuneration packages for replacement positions; and the fourth meeting was to discuss and agree NHS England and Improvement's guidance regarding annual 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 set out in appendix 6.1.

The committee was materially assisted in its considerations at all meetings held in 2021/22 by Geraldine Opreshko, director of workforce and organisational development and subsequently Lawrence Anderson, interim director of workforce and organisation development. This was in virtual attendance 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 which follows, setting out information subject to audit.

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

01 April 2021 – 31 March 2022		
Total number of governors in office	Number of governors receiving expenses in 2021/22	Aggregate sum of expenses paid in 2021/22 (rounded to the nearest £00)
26 served for all or part of 2021/22	1	£0*
*£25.20		

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

Senior Manager Remuneration Table 2021/22

SALARY AND PENSION ENTITLEMENTS OF VERY SENIOR MANAGERS

A) Remuneration table 2021/22

			2021/22	2021/22	2021/22	2021/22	2021/22	2021/22	2021/22
			Salary and fees (in bands of £5,000)	Taxable benefits (total to the nearest £100)	Annual performance-related bonuses (in bands of £5,000)	Long-term performance-related bonuses (in bands of £5,000)	All pension-related benefits (in bands of £2,500) **	Other remuneration	Total
Senior Manager	Role	Date References	£000s, bands of £5k	£s, to the nearest £100	£000s, bands of £5k	£000s, bands of £5k	£000s, bands of £2.5k	£000s, bands of £5k	£000s, bands of £5k
Altman K *	Medical Director	to 16/01/2022	120 - 125	-	- - -	- - -	- - -	- - -	**120 - 125**
Dillon-Robinson P	Non-Executive Director		10 - 15	-	- - -	- - -	- - -	- - -	**10 - 15**
Gould K	Non-Executive Director		10 - 15	-	- - -	- - -	- - -	- - -	**10 - 15**
Hobson B	Chair	to 30/09/2021	20 - 25	-	- - -	- - -	- - -	- - -	**20 - 25**
Jago A	Director of Operations	to 06/03/2022	100 - 105	-	- - -	- - -	17.5 - 20.0	- - -	**120 - 125**
Jenkin S	Chief Executive		145 - 150	-	- - -	- - -	35.0 - 37.5	- - -	**180 - 185**
Miles M	Director of Finance and Performance		120 - 125	-	- - -	- - -	- - -	- - -	**120 - 125**
Needle G	Non-Executive Director		15 - 20	-	- - -	- - -	- - -	- - -	**15 - 20**
Norman K	Non-Executive Director		10 - 15	-	- - -	- - -	- - -	- - -	**10 - 15**
Opreshko G	Director of Workforce and Organisational Development	to 09/06/2021	25 - 30	-	- - -	- - -	12.5 - 15.0	- - -	**35 - 40**
Pirie C	Director of Communications and Corporate Affairs		100 - 105	-	- - -	- - -	45.0 - 47.5	- - -	**150 - 155**

Reeves N	Chief Nurse		110	-	115	-	-	-	-	-	-	-	265.0	-	267.5	-	-	-	**375**	-	**380**
Anderson L	Interim Director of Workforce	from 10/06/2021	70	-	75	-	-	-	-	-	-	-	65.0	-	67.5	-	-	-	**140**	-	**145**
Cubison T	Medical Director* **	from 19/01/2022	15	-	20	-	-	-	-	-	-	-	-	-	-	-	-	-	**15**	-	**20**
Morrison-McCabe S	Director of Operations	from 21/03/2022	0	-	5	-	-	-	-	-	-	-	-	-	-	-	-	-	**0**	-	**5**
Donley A	Interim Chair	from 15/11/2021	15	-	20	-	-	-	-	-	-	-	-	-	-	-	-	-	**15**	-	**20**

*2021/22 the salary for the Medical Director role was £15k pa
**T Cubison has a clinical role which is charged from the MoD inclusive of any pension etc. at a cost of £15k for the period as MD this year

** The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

Senior Manager Remuneration Table 2020/21

SALARY AND PENSION ENTITLEMENTS OF VERY SENIOR MANAGERS																										
A) Remuneration table 2020/21																										
			2020/21			2020/21			2020/21			2020/21			2020/21			2020/21			2020/21					
			Salary and fees (in bands of £5,000)			Taxable benefits (total to the nearest £100)			Annual performance-related bonuses (in bands of £5,000)			Long-term performance-related bonuses (in bands of £5,000)			All pension-related benefits (in bands of £2,500) **			Other remuneration			Total					
Senior Manager	Role	Date References / Units	£000s, bands of £5k			£s, to the nearest £100			£000s, bands of £5k			£000s, bands of £5k			£000s, bands of £2.5k			£000s, bands of £5k			£000s, bands of £5k					
Altman K *	Medical Director		170	-	175	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	**170**	-	**175**		
Dillon-Robinson P	Non-Executive Director		10	-	15	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	**10**	-	**15**		
Gould K	Non-Executive Director		10	-	15	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	**10**	-	**15**		
Hobson B	Chair		40	-	45	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	**40**	-	**45**		
Jago A	Director of Operations		105	-	110	-	-	-	-	-	-	-	-	-	52.5	-	55.0	-	-	-	-	**160**	-	**165**		
Jenkin S	Chief Executive		145	-	150	-	-	-	-	-	-	-	-	-	35.0	-	37.5	-	-	-	-	**180**	-	**185**		
Miles M	Director of Finance and Performance		125	-	130	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	**125**	-	**130**		
Needle G	Non-Executive Director		10	-	15	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	**10**	-	**15**		
Norman K	Non-Executive Director		10	-	15	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	**10**	-	**15**		
Opreshko G	Director of Workforce and Organisational Development		100	-	105	-	-	-	-	-	-	-	-	-	25.0	-	27.5	-	-	-	-	**130**	-	**135**		
Pirie C	Director of Communications and Corporate Affairs		85	-	90	-	-	-	-	-	-	-	-	-	50.0	-	52.5	-	-	-	-	**140**	-	**145**		
Thomas J	Director of Nursing and Quality	Retired November 2020	80	-	85	-	-	-	-	-	-	-	-	-	5.0	-	7.5	-	-	-	-	**85**	-	**90**		

Reeves N	Interim Director of Nursing and Quality	From November 2020	35	-	40	-	-	-	-	-	-	-	37.5	-	40.0	-	-	-	**70**	-	**75**

*Salary attributable to the Medical Director's clinical role is £158k

** The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

SALARY AND PENSION ENTITLEMENTS OF VERY SENIOR MANAGERS

B) Pension benefits table 2021/22

			Real increase in pension at pension age (bands of £2,500) £'000	Real increase in pension lump sum at pension age (bands of £2,500) £'000	Total accrued pension at pension age at 31 March 2022 (bands of £5,000) £'000	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000) £'000	Cash equivalent transfer value at 01-April-21 £'000	Real increase in cash equivalent transfer value £'000	Cash equivalent transfer value at 31-Mar-22 £'000
Jago	**A**	**Director of Operations**	0-2.5	0	30-35	50-55	442	26	473
Jenkin	**S**	**Chief Executive**	2.5-5.0	0	15-20	0	213	57	271
Opreshko **	**G**	**Director of Workforce and Organisational Development**	0-2.5	0	10-15	0	128	0	0
Pirie	**C**	**Director of Communications and Corporate Affairs**	2.5-5.0	2.5-5.0	25-30	45-50	406	53	461
Reeves	**N**	**Chief Nurse**	10-12.5	35-37.5	50-55	155-160	900	302	1206
Anderson	**L**	**Interim Director of Workforce and Organisational Development**	2.5-5.0	5-7.5	15-20	30-35	175	47	233
Morrison-McCabe	**S**	**Director of Operations**	0	0	40-45	85-90	803	0	804

Please note M Miles, K Altman and T Cubison are not active members of the scheme and therefore not actively accruing greater benefits in this position as Director. ** Retired during 2021-22

The employer does not contribute to any stakeholder pension schemes for these managers.

SALARY AND PENSION ENTITLEMENTS OF VERY SENIOR MANAGERS

B) Pension benefits table 2020/21

			Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2021 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000)	Cash equivalent transfer value at 01-April-20	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31-Mar-21
			£'000	£'000	£'000	£'000	£'000	£'000	£'000
Jago	**A**	**Director of Operations**	2.5-5.0	2.5-5.0	25-30	50-55	383	52	442
Jenkin	**S**	**Chief Executive**	2.5-5.0	0	10-15	0	156	54	213
Opreshko	**G**	**Director of Workforce and Organisational Development**	0-2.5	0	5-10	0	94	32	128
Pirie	**C**	**Director of Communications and Corporate Affairs**	2.5-5.0	2.5-5.0	20-25	45-50	347	54	406
Thomas	**J**	**Director of Nursing and Quality ****	0-2.5	0-2.5	40-45	120-125	880	0	0
Reeves	**N**	**Interim Director of Nursing and Quality**	0-2.5	5-10	40-45	120-125	764	47	900

* No longer an active member of the scheme and therefore not actively accruing greater benefits in this position as Director. ** Retired during 2020-21

The employer does not contribute to any stakeholder pension schemes for these managers.

SALARY AND PENSION ENTITLEMENTS OF VERY SENIOR MANAGERS

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 2021/22.

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 Disclosures 21/22

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in the organisation in the financial year 2021-22 was £145k to £150k (2020/21, £150k to 155k). This is a reduction between years of 3%. This is due to a change in the make-up of the Board which has triggered a change in the highest paid director.

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

For employees of the Trust as a whole, the range of remuneration in 2021-22 was from £18k to £196k (2020-21 £17k to £201k). The percentage increase in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 7%. 10 employees received remuneration in excess of the highest-paid director in 2021/22 (2020/21 also 10).

Note that there were no performance pay, bonuses or benefits- in-kind.

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

Percentile Information+A12			
Figures for 2021/22			
	25th Percentile	Median	75th Percentile
Total Pay and Benefits - All Staff	23,304	34,827	49,282
Total Pay and Benefits - Highest Paid Director	147,500	147,500	147,500
Total Pay and Benefits - Ratio	6.3	4.2	3.0
Figures for 2020/21			
	25th Percentile	Median	75th Percentile
Total Pay and Benefits - All Staff	22,223	32,273	45,753
Total Pay and Benefits - Highest Paid Director	152,500	152,500	152,500
Total Pay and Benefits - Ratio	6.9	4.7	3.3

Steve Jenkin
Chief Executive and Accounting Officer
15 June 2022

3.3 Staff report

Analysis of average staff numbers

2021/22 Data													
PERMANENTLY EMPLOYED													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average
Headcount	1,110.00	1,102.00	1,107.00	1,100.00	1,122.00	1,101.00	1,109.00	1,104.00	1,116.00	1,118.00	1,132.00	1,126.00	1,112.25
FTE	919.28	922.25	914.27	907.98	900.68	898.41	907.68	913.85	920.03	924.20	919.17	921.28	914.09
TEMPORARY STAFF-BANK, LOCUM, AGENCY													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Non-medical bank	60.39	55.64	62.77	60.17	60.18	56.45	61.26	66.72	25.99	71.04	73.41	76.98	60.92
Non-medical agency	4.55	8.31	8.12	8.57	7.18	4.87	3.18	5.79	6.92	6.19	6.71	5.07	6.29
Medical locums	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Medical bank	8.68	11.41	11.57	13.93	17.96	13.41	10.83	13.08	9.71	8.05	14.12	11.98	12.06
Medical agency	1.72	2.55	4.16	1.49	1.23	0.56	0.31	3.89	2.29	1.32	1.19	1.85	1.88
Total average full time equivalent staff numbers 2021/22													**995.24**

The table above shows the average number of staff employed by the Trust each month in 2021/22. Further information, including staff turnover, can be found in nationally reported figures published by NHS Digital on the following link https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

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

The table below shows the gender breakdown in the Trust.

2021/22 data						
	Chief executive	Executive directors	Non-executive directors	Other senior managers	All other employees	Total
Female	0	3	2	2	825	832
Male	1	0	3	1	258	263
Total						1096

Data for 31 March 2022

The Trust publishes an annual gender pay gap report and associated action plan. Reports are published on the Trust website and on the Cabinet Office website at gender-pay-gap.service.gov.uk

Sickness absence data

2021/22 Data		
Total full time equivalent staff years available	**Total days lost**	**Average number of days of sickness absence per full time equivalent employee**
921	11,727	7.9

Sickness for 01/01/21 - 31/12/21 as at 26/04/22

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

Employee benefits and staff numbers

Employee benefits

	2021/22 Total £000	2020/21 Total £000
Salaries and wages	44,403	42,957
Social security costs	4,411	4,178
Apprenticeship levy	205	193
Employer's contributions to NHS pensions	7,241	6,882
Pension cost - other	15	15
Termination benefits	50	-
Temporary staff (including agency)	1,308	1,055
Total staff costs	**57,633**	**55,280**
Of which		
Costs capitalised as part of assets	581	434
Total Staff Costs Excluding capitalised costs	**57,052**	**54,846**

Average number of employees (WTE basis)

	Total 31 Mar 2022	Permanent 31 Mar 2022	Other 31 Mar 2022	Total 31 Mar 2021
Medical and dental	**173**	159	14	169
Ambulance staff	**0**			0
Administration and estates	**306**	280	26	300
Healthcare assistants and other support staff	**130**	127	3	133
Nursing, midwifery and health visiting staff	**229**	194	35	225
Nursing, midwifery and health visiting learners	**0**			0
Scientific, therapeutic and technical staff	**60**	57	3	63
Healthcare science staff	**99**	97	2	94
Social care staff	**0**			0
Other	**0**			0
	997	**914**	**83**	984
	5	2	3	4

Staff policies and actions applied during the financial year
During 2021/22, QVH continued to ensure all staff policies were systematically reviewed and updated to comply with changes in legislation, making sure that employment policies were in line with current good practice, and that applicants and employees are treated fairly and equitably. Key staff policies reviewed in 2021/22 included:

Policy/Guideline	Date ratified

Apprenticeship Guidelines	17 May 2021
Induction Policy	24 May 2021
Payment of Salary and Wages Policy	28 June 2021
Relocation Policy	28 June 2021
Management of Probation Periods Policy	26 July 2021
Relationships at Work Policy	26 July 2021
Managing Performance Policy	27 September 2021
Redeployment Policy	25 October 2021
Study leave for Clinical and Non-Clinical Staff	4 January 2022
Recruitment and Selection Policy	24 January 2022
Appeals Policy	28 February 2022
Management of Stress at Work Policy	28 February 2022
Leavers Policy	28 February 2022
Appraisal and Pay Progression	28 February 2022

Other actions taken in year included:

- Development of the Trust's Health and Wellbeing offering to support staff physical and psychological wellbeing with the introduction of Mental Health First Aiders and the Health Workplace Allies Network
- Introduction of the Trust's first Agile Working Policy, which embeds the learning and approaches from the pandemic into flexible working arrangements, enhancing the employment experience for staff and achieving a better work/life balance.

Policies applied during the financial year for giving full and fair consideration to applications for employment made by disabled persons, having regards to their particular aptitudes and abilities	QVH maintains 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 comprehensive recruitment and selection training for managers 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 staff with a disability and works with managers to ensure reasonable adjustments are given due consideration 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 (WDES).
Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees	The Trust's Stay Well Health and Wellbeing initiative, in partnership with the HR advisory service, organisational development and psychological therapy provide regular trust wide communications and strategies for staff for their wellbeing. The Trust's Employee Assistance Programme provider, Care First, communicate regularly to all staff where support can be found.

	During 2021/22 the chief executive continued to host regular staff briefing sessions. In 2021/22 the focus was primarily on the future plans for QVH and discussions in relation to potential merger 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 team brief cascade system, where managers pass on the detail of the briefing to their team, enhances dissemination of information and feedback from teams. Members of the executive team have attended local team meetings for Q&A sessions.
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. These meetings have continued virtually during the pandemic. Formal consultation with staff takes place through the joint consultation and negotiating committee comprising trade union and management representatives and the local negotiating committee involving managers and medical staff representatives and 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 2021/22 a range of initiatives were successfully continued - albeit virtually or ensuring social distancing - including long service awards recognition and virtual staff awards. There are bi-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 guardian, elected by the workforce, continues to report directly to the chief executive in this role. The Trust continues to work proactively with the Black, Asian and minority ethnic (BAME) network chairs who are growing the network amongst staff. This includes attendance and participation at external events and region wide initiatives. As part of QVH's commitment to equality, diversity and inclusion the Trust produces an

	annual equalities report which is publicly available on our website which provides comment and analysis on our equality, diversity and inclusion metrics, our action plans and areas we wish to enhance and improve our support to staff from under-represented groups.
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 Cordell Health 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, although this has taken place virtually with telephone triage in most instances. The Trust is committed to the violence prevention and reduction standard and has undertaken benchmarking sessions with national and regional teams. 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 24-hour employee assistance programme which provides comprehensive advice, including legal advice.
Information on policies and procedures with respect to countering fraud and corruption	QVH takes fraud and corruption very seriously and regularly reviews processes to ensure that opportunities for fraud are minimised. There are also training sessions for staff and managers from the counter fraud team. These include training sessions for the recruitment team on right to work documentation and visual checks. 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 Counter Fraud Authority training has been revised and an annual counter fraud survey undertaken.

The board of directors was provided with an annual report on workplace equality and diversity in January 2022 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 website. Progress against an action plan continues to be formally reported through the committee structure on a bi-annual basis.

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.

The establishment of the QVH BAME network has been very positively received by the workforce and the co-chairs receive ongoing support, guidance and mentoring from the NHS England and NHS Improvement regional team. Furthermore, the Trust has introduced BAME representation onto senior post recruitment panels and advisory appointment committees to bring a broader recruitment panel representation.

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 2021/22 the Trust had no off-payroll arrangements.

All off-payroll engagements as of 31 March 2022, for more than £245 per day and that last for longer than six months	
Number of existing engagements as of 31 March 2022	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 2021 and 31 March 2022, 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 2021 and 31 March 2022	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 2021 and 31 March 2022

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 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 2021/22 QVH made two payments in this category; both of which were payments in lieu of notice within contractual terms.

2021/22 exit packages		
Contractual Costs	**Agreement Number**	**Total Value of Agreements £000**
Voluntary Redundancies including early retirement	0	
Mutual agreed resignations (MARS)	0	
Early Retirements in the efficiency of the service	0	
Contractual payments in lieu of notice	2	£50,035.45
Exit payments following Employment Tribunals or court orders	0	
Non-contractual payments requiring HMT approval	0	
Total number of exit packages by type	2	£50,035.45
Total resource cost	£50,035.45	-

Trade union facility time disclosures

Queen Victoria Hospital NHS Foundation Trust Trade Union Facility Time Regulations (2017) 2021/22 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*
4	*4*
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%	4
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	£4,858
Provide the total pay bill	£56,815,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.009%
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. This throughout a period of a pandemic and significant pressure on the NHS has never been more important.

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.

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.

The goals laid out in our people and organisational development strategy clearly sets out the Trust's vision, ambitions and plans for the development of QVH through our workforce. These goals are aligned to many of the themes in the staff survey carried out in 2021:

People and OD Goals	People Promise Themes
1. Engagement and communication	- We are compassionate and inclusive - We have a voice that counts
2. Attraction and retention	- We are recognised and rewarded - We work flexibly
3. Health and wellbeing	- We are safe and healthy
4. Learning and education	- We are always learning
5. Talent and leadership	- We are a team

NHS staff survey
The revision of the survey for 2021 is the most significant change for at least a decade. The national People Plan 2020/21 committed that the NHS Staff Survey would be redesigned to align with Our People Promise. This was an opportunity to update, modernise and maintain the relevance of the Staff Survey. The scope of the refresh, based on widespread and significant engagement with stakeholders and key data users, covers the following key areas:

- aligning with the People Promise
- increasing participation and inclusivity
- maintaining comparability of survey results for key indicators.

From 2021 onwards the questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of our NHS people, the things that would most improve our working experience, such as health and wellbeing support, the opportunity to work flexibly, and to feel we all belong whatever our background or our job. The People Promise is made up of seven elements:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team.

Additionally two further elements are also assessed bringing the total to nine. These are measuring staff engagement and morale.

To maintain comparability of survey results for key indicators, all survey questions included in the 2021 survey have been through a rigorous, multi-phase cognitive testing procedure (involving NHS staff) that conforms to best practice in survey development. Some existing questions that had a weak alignment to the People Promise have been removed. The majority of questions and some key indicators have been maintained and historical comparability will be upheld wherever possible to help ensure results are of the highest value and can be compared year on year. Staff Engagement, WRES and WDES indicators remain identical to last year and therefore reporting will remain the same.

A total of 117 questions were asked in the 2021 survey; of these 56 can be historically compared to 2020 and a further four to 2019.

The Trust ran a mixed mode survey; specific areas were targeted to receive a paper survey and we increased the number of online surveys due to this achieving a higher response rate in the previous year. In 2021 the online surveys showed a 66% return rate (621 responses out of 941 invites) compared to 50% in 2020 once ineligibles were removed. The table below shows 2021 response rate details:

Outcome	Paper	Online	Total
Invited	115	941	1056
Blank	0	0	0
Completed	58	621	679
Excluded	0	0	0
Ineligible	0	0	0
Left organisation	0	3	3
Not returned	57	314	371
No further mailings	0	2	2
Opted out	0	1	1
Undelivered	0	0	0

In total (online and paper) QVH surveyed 1,056 eligible staff compared to 1,059 in 2020; of these, 679 responded making a 64.5% return, an increase from 58.7% the year before. The 2021 benchmarking group for acute specialist trusts has 13 organisations and showed a 54% return rate overall.

	2017	2018	2019	2020	2021
Highest	62.0%	63.2%	69.6%	65.6%	69.6%
Your org	54.9%	52.2%	58.1%	58.7%	64.5%
Median	52.8%	52.8%	58.1%	56.1%	54.0%
Lowest	38.0%	40.5%	46.3%	38.6%	41.0%

Out of the 56 historically comparable questions asked in the 2021 Staff Survey, 1 was significantly better, 52 had no significant difference and 3 were significantly worse than 2020 (see appendix 2 results).

The three 'core questions' relate to the organisation prioritising patient care, to staff recommending as a place to work and to staff being happy with standard of care if a friend or relative needed treatment; these are shown below. QVH has seen a 0.9% increase for the question related to prioritising patient care (Q21a), a slight decrease of 0.5% for recommending as a place to work (Q21c) and a decrease of 0.8% for being happy with standard of care for a friend or relative (Q21d). Compared to other acute specialist trusts, QVH is above average for Q21a and Q21d and average for Q21c.

Q21a
Care of patients / service users is my organisation's top priority

	2017	2018	2019	2020	2021
Best	90.9%	92.7%	91.9%	91.8%	90.1%
Your org	81.2%	85.3%	88.0%	87.1%	88.0%
Average	86.7%	86.9%	87.3%	89.3%	87.4%
Worst	77.0%	76.8%	83.2%	83.0%	79.0%
Responses	501	490	574	594	636

Q21c
I would recommend my organisation as a place to work

	2017	2018	2019	2020	2021
Best	76.1%	79.5%	80.9%	79.3%	74.0%
Your org	57.8%	63.1%	72.9%	71.2%	70.7%
Average	72.9%	72.5%	73.9%	74.8%	70.7%
Worst	57.8%	59.8%	62.7%	66.0%	56.7%
Responses	501	491	560	593	637

Q21d
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation

	2017	2018	2019	2020	2021
Best	93.1%	94.8%	94.9%	95.5%	94.0%
Your org	87.4%	90.9%	91.7%	93.6%	92.8%
Average	89.9%	90.1%	90.0%	91.7%	89.6%
Worst	80.0%	77.7%	80.9%	82.0%	69.1%
Responses	500	491	572	594	637

A summary of QVH's most and least improved results for 2021 is shown below. These will be looked at in greater detail in each area to identify any trends.

Most improved scores	Trust 2021	Trust 2020
q13d. Last experience of physical violence reported	75%	55%
q11e. Not felt pressure from manager to come to work when not feeling well enough	78%	71%
q9c. Immediate manager asks for my opinion before making decisions that affect my work	61%	55%
q9b. Immediate manager gives clear feedback on my work	66%	62%
q7b. Team members often meet to discuss the team's effectiveness	59%	56%

Most declined scores	Trust 2021	Trust 2020
q3i. Enough staff at organisation to do my job properly	35%	45%
q22b. I am unlikely to look for a job at a new organisation in the next 12 months	53%	59%
q22a. I don't often think about leaving this organisation	46%	52%
q4a. Satisfied with recognition for good work	59%	64%
q4d. Satisfied with opportunities for flexible working patterns	56%	60%

Summary details of local surveys and results

National quarterly pulse score	Data period	QVH Trust value	Change	Quartile
Employee engagement score	Q4 2021/22	7.5	Improved by 0.4	4 - Highest 25%
Advocacy score	Q4 2021/22	8.2	Improved by 0.5	4 - Highest 25%
Involvement score	Q4 2021/22	7.2	Improved by 0.7	4 - Highest 25%
Motivation score	Q4 2021/22	7.1	Remained the same	4 - Highest 25%
Employee engagement score	Q2 2021/22	7.1		4 - Highest 25%
Advocacy score	Q2 2021/22	7.7		4 - Highest 25%
Involvement score	Q2 2021/22	6.5		3 - Mid/High 25%
Motivation score	Q2 2021/22	7.1		4 - Highest 25%

NHS national quarterly pulse staff (Previously known as the staff friends and family test)

The People Plan 2020/21 committed to supporting avenues that help ensure staff have a voice. During the pandemic the staff friends and family test (SFFT) was on hold whilst the NHS focussed on other priorities. In April 2021 SFFT was been relaunched under a new name, the national quarterly pulse survey (NQPS) and is open for staff at QVH to give their views.

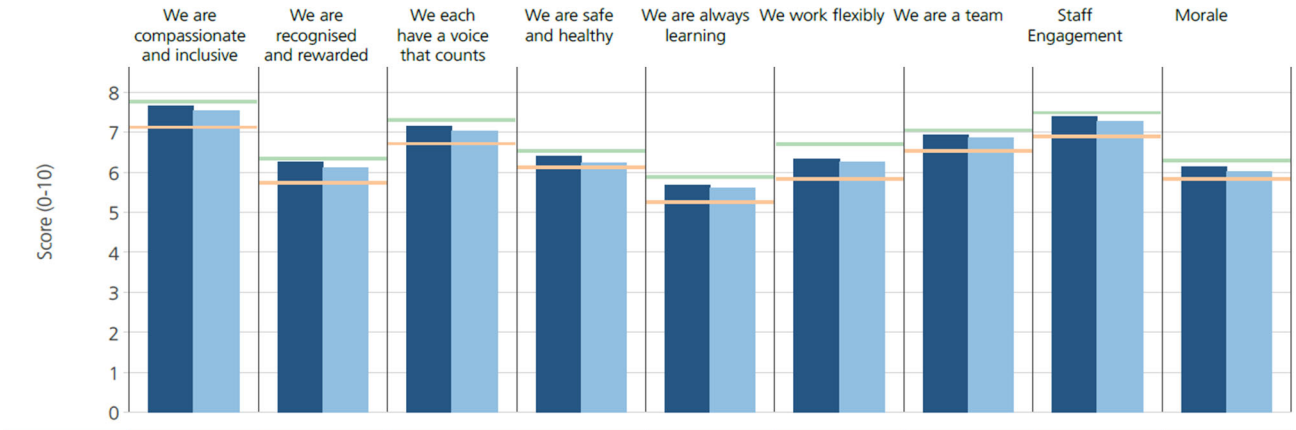
The NHS People Plan and the Government want to look at morale across the NHS and have amended the NQPS to focus on staff engagement, which is closely aligned to the national staff survey. The nine engagement theme questions from the annual staff survey provide insight into motivation, involvement and advocacy:

- *Motivation*: enthusiasm for the activities of the job
- *Involvement*: employees feel that they have opportunities to suggest and make improvements
- *Advocacy*: belief that the organisation is a good employer as well as service provider and is worthy of recommendation to others.

The NQPS continues to run on a quarterly basis using these core areas to help to gain insight into staff engagement across the NHS.

Key comparisons

When compared with the seven People Promise scores of other acute specialist trusts, QVH is above average on five and average on two of the elements. On the themes of staff engagement and morale, QVH is above average.



Best	7.8	6.3	7.3	6.5	5.9	6.7	7.1	7.5	6.3
Your org	7.6	6.3	7.1	6.4	5.7	6.3	6.9	7.4	6.1
Average	7.5	6.1	7.0	6.2	5.6	6.3	6.9	7.3	6.0
Worst	7.1	5.7	6.7	6.1	5.3	5.8	6.5	6.9	5.8

Questions/areas of improvement

In-depth analysis of the 2021 NHS staff survey question data highlights specific questions/areas where QVH has improved

PP	Q	Description	2020	2021	Change
7	q7b	Team members often meet to discuss the team's effectiveness	55.9%	59.3%	3.4%
7	q9b	Immediate manager gives clear feedback on my work	61.7%	65.6%	3.9%
*7	q9c	Immediate manager asks for my opinion before making decisions that affect my work	55.2%	61.1%	5.9%
N/A	q11e	Not felt pressure from manager to come to work when not feeling well enough	71.3%	78.4%	7.1%
*4	q13d	Last experience of physical violence reported	54.5%	75.0%	20.5%

Areas for development

It has not been easy to draw comparisons to the 2020 results to understand where significant reductions in scores have been seen. However, when comparing individual questions and scores areas are identified where QVH will focus its actions for improvement.

PP	Q	Description	2020	2021	Change
SE	q2b	Often/always enthusiastic about my job	75.2%	72.1%	3.1%
3	q3f	Able to make improvements happen in my area of work	59.1%	55.5%	3.6%
4	q3h	Have adequate materials, supplies and equipment to do my work	66.9%	63.8%	3.1%
*4	q3i	Enough staff at organisation to do my job properly	44.7%	35.2%	9.5%
2	q4a	Satisfied with recognition for good work	63.6%	58.8%	4.7%
2	q4b	Satisfied with extent organisation values my work	52.9%	49.0%	3.9%
6	q4d	Satisfied with opportunities for flexible working patterns	60.4%	55.8%	4.6%
4	q11d	In last 3 months, have not come to work when not feeling well enough to perform duties	59.5%	55.7%	3.8%
4	q14a	Not exp harassment, bullying or abuse from patients/service users, relatives or members of public	83.8%	80.4%	3.4%
*M	q22a	I don't often think about leaving this organisation	52.4%	46.1%	6.4%
*M	q22b	I am unlikely to look for a job at a new organisation in the next 12 months	59.1%	52.7%	6.4%

Summary of themes

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 is a continuing correlation between the impact of Covid-19 and the responses to some of the themes in the 2021 survey. Themes that need improvement can be linked to the impact of restoration and recovery of services alongside business as usual.

The Trust will continue to triangulate key findings from the NHS staff survey report alongside the detailed report from Picker (the independent facilitator of the QVH survey); people and organisational development strategy; and the stay/exit interviews with staff to ensure we effectively listen and respond to the needs of staff. We will work closely with the BAME network co-chairs with a focus on the experience of staff from a BAME background.

Summary of ongoing actions

Bringing together the key areas throughout the 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 the areas for development. This will be undertaken in collaboration with key stakeholders including business units, and colleagues in the communications, workforce and organisational development and learning teams.

A range of interventions are already underway including:

- Establish and embed and education and development steering group to discuss priorities and workforce strategy across the year
- Ongoing promotion of education, learning and development across virtual platforms and as the year progresses offer a more blended approach to learning
- Continued promotion of our successful apprenticeship programmes across the trust
- Continue to promote and develop management and leadership opportunities in house and externally across the wider system including talent management across the Sussex health and care system
- Working with business units in relation to specific team interventions and staff survey themes
- Continue StayWell initiatives and build upon 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
- Use the People Promise diagnostic tool in the Model Health System to compare outcomes over time and benchmark against elements of the Promise elements.

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 2021/22 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 5 August 2021. 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 constitution and standing orders (published to the Trust's website) provide the framework for decision making and delegation between the board of directors, council of governors and executive management team, including how any disagreements between the council of governors and the board of directors will be resolved.**				

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 6.1.				
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 6.2.				
4.	Additional requirement of NHS foundation trust annual reporting manual (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 6.1 and 6.2.				
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 6.3. 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 6.1. **Suspension or removal of the Chair or another non-executive director shall require a resolution to be submitted by three quarters of the members of the Council of Governors and sponsored by at least one Governor.** **The governor sponsoring the resolution shall set out in writing the reasons in support of the resolution. At the meeting of the Council of Governors where the resolution is to be considered and voted upon, the Chair or other non-executive director, who is the subject of the resolution, shall be given the opportunity to respond to the reasons given. If the individual fails to attend the meeting without due cause, the meeting may proceed in their absence. The decision to proceed in these circumstances shall be at the sole discretion of the meeting Chair.** **In making the decision to remove the Chair or another non-executive director, the Council of Governors shall take into account the results of the annual appraisal concerning the individual in question. The Council of Governors shall also remove or suspend a non-executive director in consultation with the Chair (if the matter concerns another non-executive director) or the senior independent director (if the matter concerns the Chair).** **If any resolution to suspend or remove either the Chair or another non-executive director is not approved at the meeting of the Council of Governors where the matter was considered, no further resolution can be put forward to suspend or remove such non-executive director, or the Chair, which is based on the same reasons, within twelve calendar months of the date of the meeting at which the resolution was considered.**				

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- Remuneration report				
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.
In July 2021, following a recruitment process carried out without the support of an external search consultancy, the Council of Governors approved the appointment of a new Chair who unfortunately then had to withdraw at short notice for health reasons. The Senior Independent Director covered the role of Chair from 1 October 2021 to 14 November 2021. With the support of NHSEI the Trust appointed Anita Donley as interim Chair taking up the role on 15 November 2021. In March 2022 work began on recruiting a Chair. This work was ongoing at year end and was carried out with the support of an external search consultancy.				
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.

Compliant: The QVH outlook for 2021/22 was presented at the annual general meeting and annual members meeting (AGM/AMM) held on 19 July 2021, to which all members were invited. Information on strategy and development is included on the public website, 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 to support informed discussion of forward plans.				
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 2021/22.				
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 2022, the board considered an internal evaluation report which covered the collective performance of the board, the performance of its committees and the individual and collective 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.**				
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 2021/22.				
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 FT 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 2021/22 the Trust's internal audit function was provided by RSM UK 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 2021/22 included: • **Patient experience/complaints** • **Financial systems and payroll** • **Information governance (DSP oolkit)** • **Statutory and mandatory training** • **Remote and new ways of working** • **Workforce planning, resource, recruitment and retention** • **Business cases (plans on a page)** • **Data quality and performance – including waiting lists**				
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 2021/22.				

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 2021/22 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.

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 2021 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.

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 and surveys of members' opinions and consultations.
Compliant: Directors attend all meetings of the council of governors held in public. In 2021/22 council meeting agendas continued to be refined to provide more opportunities for non-executive directors (NEDs) to report to the council and for dialogue between NEDs and governors generally. **Through the first three quarters of 2021/22 the lead governor was invited to attend all meetings of the board of directors including seminars, workshops and meeting sessions held in private. This practice and the attendance of governors at sub-committees of the Board was ended in quarter 4 in line with the recommendations of the Independent Review into the Trust's handling of challenges encountered in progressing the merger proposal with University Hospitals Sussex. These changes were made to support clarity around the distinct roles of governors and non-executive directors and bring the Trust in line with recognised best practice nationally.**				
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.				
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 leonora.may1@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 2022, the number of members within the public constituency was 7,546 and the staff constituency was 1,096. **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 19 July 2021.** **Additional information regarding membership of the QVH Foundation Trust can be found online at 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 the Trust's public website and may also be requested 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 chief nurse; head of risk, clinical quality and patient safety; 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 of governors 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 was updated in March 2022 and published to the Trust's website. The Trust's standards of business conduct and behaviour policy was updated in 2020/21, 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 of governors, meet the independence criteria set out in B.1.1. A chief executive should not go on to be the chairperson of the same NHS Foundation Trust.
Compliant.				
34.	6: Comply or explain	Board	A.4.1	In consultation with the council of governors, 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 in October 2019.				
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 weeks throughout 2021/22.				
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 2021/22.				
37.	6: Comply or explain	Council of governors	A.5.1	The council of governors should meet sufficiently regularly to discharge its duties.
Compliant.				
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 16 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 England and NHS Improvement (Monitor) publishes guides to the duties and legal obligations of foundation trust 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 of governors 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 of governors 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 of governors should ensure its interaction and relationship with the board of directors is appropriate and effective.

There are several roles and functions that support the council of governors to have appropriate and effective interactions and relationships with the board of directors. 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 role of lead governor and the work of the appointments committee.

On 20 October 2021, following a referral from the Trust to NHS Improvement, the Trust received a notice of imposition of additional license conditions from NHS Improvement under section 111 of the Health and Social Care Act 2012. NHS Improvement's notice identified a deterioration in the relationship between the board and the council of governors including a motion passed on 19 July 2021 for the Board to pause work on merger proposals. The NHS Improvement notice highlighted that '*the Council and Board appear no longer to have a fully effective working relationship'* and that further actions by the council to prevent or hinder development of a sustainable long term plan could '*destabilise the Trust's management, governance and services.'* The additional licence conditions related to the need for the council of governors to implement arrangements to work effectively with the board and to ensure that the Trust has sufficient and effective board leadership, capacity and capability.

An independent review of the Trust's handling of challenges encountered in progressing the merger proposal was commissioned, and reported in February 2022. The independent review considered the processes for engaging with staff and governors, handling of external stakeholders and clarity on decision making roles between the board and governors. The report highlighted a '*serious breakdown in relationships between the Board and the Governors, to the extent that trust between the groups is now very limited.*' The report noted that agenda items other than the merger had been marginalised at council of governors meetings such that '*the Governors are not exercising the extent of their role.'*

The independent review recommended supporting governors to discharge all their statutory responsibilities effectively and ensuring that roles of governors are clear by:

- **having dedicated meetings with all governors on matters relating to the merger process, and not including the merger process on other agendas such that governors are able to engage effectively on other matters**
- **ceasing the practice of lead governor attendance at private board meetings**
- **ceasing the practice of governor representative attendance at sub-committees of the board.**

The Trust board has fully accepted the recommendations of the independent review. The board and council of governors are working to ensure future interactions and evolving relationships are appropriate and effective.

43.	6: Comply or explain	Council of governors	A.5.8	The council of governors 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 2021/22. 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 of governors 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 of governors 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 of governors should take into account the views of the board and the nominations committee on the qualifications, skills and experience required for each position.
Compliant: 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.				
54.	6: Comply or explain	Council of governors	B.2.8	The annual report should describe the process followed by the council of governors 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 2021/22.				
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. 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.**				
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 consultation with the lead governor and in line with the national framework for conducting annual appraisals of NHS provider chairs. **See 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 director of communications and corporate affairs.				
63.	6: Comply or explain	Chair/council of governors	B.6.5	Led by the chairperson, the council of governors should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities.
The collective performance of the council is usually reviewed every three years. The council's governor steering group agreed to a 12-month postponement of the review scheduled in 2021, in the context of the challenges described in 42 above. Following regulatory intervention in Q3 additional conditions were applied to the Trust's licence and an independent review commissioned (see 42 above). All recommendations of the independent review were accepted by the board and an action plan to implement them was developed in Q4. The Trust will reconsider the review of collective performance of the Council of Governors after sufficient time has elapsed to allow the new working culture to become fully embedded. **The Trust sent members a copy of its QVH News newsletter by post or email according to their preference, as well as additional news updates for 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 of governors, 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. In line with a recommendation of the independent review, the Trust will also set out the process that will be followed if a governor may have breached any of the Nolan principles, including if a member of staff believes they are being bullied or harassed.				
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 a 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 2021/22.				
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 – Going Concern.				
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 of governors 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 of governors 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 2021/22.				
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 2021/22, 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. **Assurance related to whistleblowing issues is the responsibility of the quality and governance committee, and 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, and is in line with national guidance.				

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 2021/22.				
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 of governors 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 19 July 2021.				
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 are 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 with, among others:** • **University Hospitals Sussex NHS Foundation Trust, with specific partnership work on clinical pathways** • **Surrey and Sussex Cancer Alliance and Kent and Medway Cancer Alliance** • **The Sussex Health and Care Partnership with executive directors and the Trust chair regularly participating in all of the associated working groups and meetings** • **The Kent and Medway ICS, with links made at chief executive level and representation on the QVH partnership working board** • **NHS trusts which host QVH 'spoke' services across the south east.**				
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 81 above.				

3.5 NHS Single Oversight Framework

NHS England and NHS Improvement's NHS 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 3. For trusts and systems in segment 3, NHS England and NHS Improvement regional teams will work collaboratively with them to undertake a diagnostic stocktake to identify the key drivers of the concerns that need to be resolved.

This segmentation information is the Trust's position as at 31 March 2022. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

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
15 June 2022

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 2022 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 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 board meetings, meetings of sub-committees of the board and board seminars.

In March 2022 the board approved the corporate risk management strategy. This document outlines the board's approach to the management of corporate risk, risk appetite and assurance routes.

'Essential Risk Management' training has been managed on a one-to-one basis due to the pandemic and the risk team support staff and advise as needed. Face to face training sessions will recommence in spring 2022.

Staff are fully supported with incident investigations, some have attended formal in-house training QVH is reviewing the National Patient Safety Framework to ensure investigators have nationally formalised training.

The chief nurse is the Trust's executive lead for risk, supported by the head of risk and patient safety and the head of quality and compliance.

The audit committee is responsible for oversight and scrutiny of the Trust's integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical). This includes review of all risk and control related disclosure statements; the underlying assurance processes, including the board assurance framework; policies for ensuring compliance with regulatory, legal and code of conduct requirements and any related reporting and self-certifications; policies and procedures for all work related to counter fraud and security.

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.

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 corporate risk register is divided between these two committees to allow robust review of the relevant risks for each 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, with the chair of each board sub-committee presenting an assurance report to council of governors meetings and well as taking questions from governors.

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 board is assured, as recorded in the annual effectiveness review considered in March 2022, 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 August 2021, 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 five years to ensure that governance arrangements remain fit for purpose. During 2017/18 QVH 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. The Trust continues to use internal processes and external best practice to review and strengthen 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:

- 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. It 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.
- NHS Improvement information and monitoring requests are responded to in a timely manner and the executive management team attend quarterly NHS Improvement performance reviews.
- Regular provider engagement meetings are held 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 the Trust meets legislative requirements and does not discriminate 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 as 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 maintained an incident response throughout the Covid-19 pandemic. The 2021 assurance process was completed in the autumn and QVH was assessed as delivering substantial assurance, an improvement from the previous partial assurance rating. The action plan to address the three standards which require review is monitored by the CCG and internally by the quality and governance committee.

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 plans in place which take account of 'Delivering a Net Zero Health Service' report under the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaption Reporting requirements are complied with.

Challenges to governance encountered in 2021/22

In February 2021, 17 new governors joined the council of governors, taking the total membership to 26. The new governors were elected in the context of the Trust's ongoing consideration of possible merger with University Hospitals Sussex. Due to the pandemic all governor meetings in 2021/22 were held virtually; this included new governor induction as well as governors seminars, and public and private council of governors meetings.

On 20 October 2021, following a referral from the Trust to NHS Improvement, the Trust received a notice of imposition of additional license conditions from NHS Improvement under section 111 of the Health and Social Care Act 2012. NHS Improvement's notice identified a deterioration in the relationship between the board and the council of governors including a motion passed on 19 July 2021 for the Board to pause work on merger proposals. The NHS Improvement notice highlighted that '*the Council and Board appear no longer to have a fully effective working relationship'* and that further actions by the council to prevent or hinder development of a sustainable long term plan could '*destabilise the Trust's management, governance and services.'* The additional licence conditions related to the need for the council of governors to implement arrangements to work effectively with the board and to ensure that the Trust has sufficient and effective board leadership, capacity and capability.

An independent review of the Trust's handling of challenges encountered in progressing the merger proposal was commissioned, and reported in February 2022. The independent review considered the processes for engaging with staff and governors, handling of external stakeholders and clarity on decision making roles between the board and governors. The report highlighted a '*serious breakdown in relationships between the Board and the Governors, to the extent that trust between the groups is now very limited.*' The report noted

that agenda items other than the merger had been marginalised at council of governors meetings such that '*the Governors are not exercising the extent of their role.'*

The independent review recommended supporting governors to discharge their statutory responsibilities effectively and ensuring that roles of governors are clear by:

- having dedicated meetings with all governors on matters relating to the merger process, and not including the merger process on other agendas such that governors are able to engage effectively on other matters
- ceasing the practice of lead governor attendance at private board meetings
- ceasing the practice of governor representative attendance at sub-committees of the board.

The Trust board has fully accepted and is delivering all the recommendations of the independent review. The issues listed above related to governors have been addressed and the board and council of governors are working to ensure future interactions and evolving relationships are appropriate and effective. Recognising the benefits of continuity at this stage, the Council of Governors took the decision in February 2022 not to hold public governor elections in 2022. The next public and staff governor elections will be in 2023.

The Trust board has also actioned the recommendations of the independent review related to governance and delivery of the programme of work on possible merger with University Hospitals Sussex. This includes the appointment of an independent clinical lead to support the development of a clinical strategy and operating model; clinical engagement will be at the heart of this alongside wider engagement with staff, patients and stakeholders. An internal process has been established for reviewing the case for change, the long-list of options, the hurdle criteria, the shortlist of options, the evaluation criteria, and the appraisal leading to the preferred option. A resourcing plan is being developed to support the delivery of the work programme with resource commensurate to the task.

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

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 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

The Trust regards any data breach extremely seriously and voluntarily reports significant breaches to the Information Commissioners Office, (ICO) as soon as it is made aware. This includes informing all data subjects involved, initiating a root cause analysis investigation, ensuring that the outcomes are formally assessed, lessons learned and actions monitored and completed.

No serious incidents were reported in 2021/22.

Data Security and Protection Toolkit

The data security and protection toolkit sets out the National Data Guardian's data security standards. These standards apply to every health and social care organisation and provide assurance to every person who uses our services that their information is handled correctly and protected throughout its lifecycle from unauthorised access, loss, damage or destruction. Completing the toolkit self-assessment, by providing evidence against assertions, demonstrates that the Trust is meeting the national data guardian standards. This increases public confidence that the NHS and its partners can be trusted with data. The toolkit can be accessed by members of the public to view participating organisations' assessments.

An NHS organisation is graded as, 'standards not met' 'standards met or 'standards exceeded' The Trust achieved a 'standards exceeded' rating for its 2021/22 submission, one of only a small number of Trusts to do so. All mandatory requirements were met.

Cyber security
Cyber security is recognised as one of the biggest operational threats to the NHS and is one of the main areas of focus for the information governance work agenda.

NHS Digital has incorporated a cyber security service into its care computing emergency response team. The intention is to enhance cyber resilience across the health and social care system by looking for emerging threats and advising healthcare organisations on how to deal with them. QVH receives alerts and acts upon them.

The Cyber Essentials scheme has been developed nationally to fulfil two functions:

- providing a clear statement of the basic controls all organisations should implement to mitigate risk through '10 steps to cyber security'
- providing an assurance framework in order that an organisation can be assessed for resilience against cyber threats.

In May 2021, QVH successfully renewed its Cyber Essentials Plus accreditation. This is the highest level of certification offered under the Cyber Essentials scheme. It is a rigorous test of an organisation's cyber security systems in which cyber security experts carry out vulnerability tests to make sure that the organisation is protected against basic hacking and phishing attacks. All sections reviewed at the time of the assessment were managed appropriately in terms of the Cyber Essentials Plus scope. The Trust has ongoing processes and procedures in place to maintain these standards.

Payment by results and clinical coding
In 2020 QVH launched a two-year project to invest in the coding team in terms of individual development, support for mentoring and training, clinician engagement and technology. A dedicated, clinically led, task and finish group was setup to deliver the following actions:

- Procurement of support package to include training, auditing, mentoring and backfill coding in times of absence
- Named consultants for coding queries for each specialty
- Educational talks from clinicians within each specialty for the coders
- Presentation from the clinical coding team leader to clinicians on importance of their part in recording in patients' clinical notes
- Introduction of clinical encoding software
- Support for members of the team to work towards further coding qualifications
- Review and implement robust internal processes, for example checking histology results and updating coding accordingly
- Regular internal mini audits to highlight areas of concern to steer training.

The annual independent clinical coding audit for 2021/22 assessed the work of the clinical coding team by taking random samples across all services provided at QVH; this showed an impressive increase in audit results as in the table below:

Area	Coding accuracy 2021/22	Coding accuracy 2020/21	Coding accuracy 2019/20	Level required – data security and protection toolkit
Primary diagnosis	98.00%	84.50%	86.00%	>=90% mandatory >=95% advisory
Secondary diagnosis	98.32%	91.11%	87.30%	>=80% mandatory >=90% advisory
Primary procedure	98.82%	94.71%	92.20%	>=90% mandatory >=95% advisory
Secondary procedure	98.63%	96.80%	92.40%	>=80% mandatory >=90% advisory

Feedback accompanying the audit result from the auditor was “A fantastic result. Quite possibly the best scoring audit I’ve ever been a part of, so a massive congratulations to the team.”

In 2022/23 the task and finish group is reviewing the process for outpatient coding and standardising this across the Trust.

Data quality and governance
Data quality refers to the tools and processes that result in the creation of the correct, complete, and valid data required to support patient care and sound decision making. Our integrated data warehouse has increased the transparency and visibility of data issues.

QVH has a data quality group with membership from a wide range of stakeholders across the Trust, this group meets monthly with a sub working group meeting more regularly to action improvement projects, ensuring its focus on key data quality issues. Once the data quality group has approved a workstream as ‘complete’ the next priority workstream commences.

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 via sub-committees
- 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 been under additional license conditions since 20 October 2021 relating to the need for the council of governors to implement arrangements to work effectively with the board and to ensure that the Trust has sufficient and effective board leadership, capacity and capability. An independent review of the Trust's handling of challenges encountered in progressing the merger proposal was commissioned, and reported in February 2022. The Trust board, as described above, is delivering all the recommendations of the independent review.

The review of governance and controls sets out how the Trust has managed risks and addressed internal control issues with the support of the regulator and an independent review. I can provide assurance that effective systems are in place to support the running of the organisation and the Trust has continued to provide high quality services for its patients.

Steve Jenkin
Chief Executive and Accounting Officer
15 June 2022

4 Auditor's report and certificate

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Queen Victoria Hospital NHS Foundation Trust ("the Trust") for the year ended 31 March 2022 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers 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 2022 and of its income and expenditure for the year then ended; and
- 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 and the Department of Health and Social Care Group Accounting Manual 2021/22.

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.

Going concern

The Directors have prepared the financial statements on the going concern basis as they have not 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. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Directors' conclusions, we considered the inherent risks to the Trust's business model and analysed how those risks might affect the Trust's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate;
- we have not identified and concur with the Directors' assessment that there is not a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Trust's high-level policies and procedures to prevent and detect fraud, as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported financial performance because of the need to achieve budgetary targets delegated to the Trust by NHS Improvement
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reviewing the Trust's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet delegated targets, we performed procedures to address the risk of management override of controls and the risk of fraudulent revenue recognition, in particular the risk that income outside of the Trust's block contract funding is accounted for in the incorrect financial period and the risk that Trust management may be in a position to make inappropriate accounting entries.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to year-end accruals and provisions.

We did not identify any additional fraud risks.

We performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included journals posted after the close of the general ledger amending the recorded surplus and unusual transactions to cash accounts.
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Investigating differences identified through the intra-NHS agreement of balances exercise to assess whether revenue had been recorded accurately and completely.
- Testing a sample of accrued expenditure recorded at the end of the year to assess whether there was a liability faced by the Trust relating to the financial period.

Identifying and responding to risks of material misstatement related to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors (as required by auditing standards), and from inspection of the Trust's regulatory and legal correspondence and discussed with the directors the policies and procedures regarding compliance with laws and regulations.

As the Trust is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The Trust is subject to laws and regulations that directly affect the financial statements, including the National Health Service Act 2006 and financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the Trust is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

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.
- in our opinion the other information has been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2021/22.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2021/22. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2021/22.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 75, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also 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

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

On 20 October 2021 the Trust was notified by NHS Improvement that it was considered to be in breach of its license conditions and needed to implement arrangements to ensure that the Board and the Council of Governors worked effectively together. An independent review commissioned into the Trust's handling of challenges encountered in progressing the merger proposal published in February 2022 further highlighted a serious breakdown in relationships between the Board and the Governors. We therefore considered that there was a significant weakness in the Trust's governance arrangements during the year.

We have raised a recommendation within our Auditor's Annual Report for the Trust to ensure that implementation of the action plan to respond to the recommendations of the independent review is appropriately monitored and the agreed actions are implemented.

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 its use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and the use of information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

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 we refer a matter to the relevant NHS regulatory body under paragraph 6 of Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the Trust incurring

unlawful expenditure, or is about to take, or has taken, a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in this respect.

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 2022 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.

Dean Gibbs
for and on behalf of KPMG LLP
Chartered Accountants
15 Canada Square, Canary Wharf, London, E14 5GL

24 June 2022

.

5 Annual accounts 2021/22

Foreword to the accounts

These accounts for the year ended 31 March 2022 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 and Accounting Officer
15 June 2022

Statement of Comprehensive Income

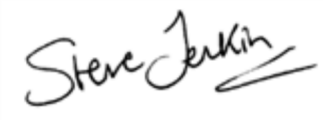
	Note	2021/22 £000	2020/21 £000
Operating income from patient care activities	3	82,409	70,786
Other operating income	4	4,582	14,365
Operating expenses	6, 8	(83,566)	(80,740)
Operating surplus from continuing operations		**3,425**	**4,411**
Finance income	11	6	1
Finance expenses	12	(101)	(127)
PDC dividends payable		(1,412)	(1,268)
Net finance costs		**(1,507)**	**(1,394)**
Other gains / (losses)	13	-	-
Surplus for the year		**1,918**	**3,017**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(748)	(171)
Revaluations	17	2,759	842
Total comprehensive income / (expense) for the period		**3,979**	**3,688**

Statement of Financial Position

	Note	31 March 2022 £000	31 March 2021 £000
Non-current assets			
Intangible assets	14	3,417	2,230
Property, plant and equipment	15	56,503	51,935
Receivables	19	332	227
Total non-current assets		**60,252**	**54,392**
Current assets			
Inventories	18	1,154	1,462
Receivables	19	3,440	4,140
Cash and cash equivalents	20	17,547	8,582
Total current assets		**22,141**	**14,184**
Current liabilities			
Trade and other payables	21	(17,387)	(10,544)
Borrowings	23	(888)	(893)
Provisions	25	(52)	(88)
Other liabilities	22	(644)	(431)
Total current liabilities		**(18,971)**	**(11,956)**
Total assets less current liabilities		**63,422**	**56,620**
Non-current liabilities			
Borrowings	23	(2,795)	(3,653)
Provisions	25	(1,048)	(908)
Total non-current liabilities		**(3,843)**	**(4,561)**
Total assets employed		**59,579**	**52,059**
Financed by			
Public dividend capital		24,546	21,005
Revaluation reserve		16,004	13,943
Income and expenditure reserve		19,029	17,111
Total taxpayers' equity		**59,579**	**52,059**

The notes on pages 92 to 128 form part of these accounts.

The accounts were approved by the Board on 15 June 2022 and are signed on the Board's behalf by:



Steve Jenkin
Chief Executive and Accounting Officer
15 June 2022

Statement of Changes in Equity for the year ended 31 March 2022

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2021	**21,005**	**13,943**	**17,111**	**52,059**
Surplus/(deficit) for the year	-	-	1,918	**1,918**
Impairments	-	(748)	-	**(748)**
Revaluations	-	2,759	-	**2,759**
Public dividend capital received (capital PDC)	3,541	-	-	**3,541**
Other reserve movements	-	50	-	**50**
Taxpayers' and others' equity at 31 March 2022	**24,546**	**16,004**	**19,029**	**59,579**

Statement of Changes in Equity for the year ended 31 March 2021

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020	**13,106**	**13,689**	**13,677**	**40,472**
Surplus/(deficit) for the year	-	-	3,017	**3,017**
Impairments	-	(171)	-	**(171)**
Revaluations	-	842	-	**842**
Public dividend capital received *	7,899	-	-	**7,899**
Other reserve movements	-	(417)	417	**-**
Taxpayers' and others' equity at 31 March 2021	**21,005**	**13,943**	**17,111**	**52,059**

* £6.3m of the Public Dividend Capital (PDC) received was conversion of revenue loans. The remaining £1.5m was capital PDC received in year.

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 and Social Care 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

	Note	2021/22 £000	2020/21 £000
Cash flows from operating activities			
Operating surplus		3,425	4,411
Non-cash income and expense:			
Depreciation and amortisation	6	4,175	3,560
Net impairments	7	(674)	(232)
Income recognised in respect of capital donations	4	-	(254)
Decrease in receivables and other assets		165	5,020
(Increase) / decrease in inventories		308	(308)
Increase / (decrease) in payables and other liabilities		3,930	(1,450)
Increase in provisions		113	60
Net cash flows from / (used in) operating activities		**11,442**	**10,807**
Cash flows from investing activities			
Interest received		6	1
Purchase of intangible assets		(1,314)	(422)
Purchase of PPE		(2,764)	(3,583)
Sales of PPE		-	-
Receipt of cash donations to purchase assets		-	79
Net cash flows from / (used in) investing activities		**(4,072)**	**(3,925)**
Cash flows from financing activities			
Public dividend capital received		3,541	7,899
Movement on loans from DHSC		(778)	(7,169)
Capital element of finance lease rental payments		(78)	(80)
Interest on loans		(114)	(179)
Interest paid on finance lease liabilities		(2)	(4)
PDC dividend (paid)		(974)	(1,677)
Net cash flows from / (used in) financing activities		**1,595**	**(1,210)**
Increase in cash and cash equivalents		**8,965**	**5,672**
Cash and cash equivalents at 1 April		**8,582**	**2,910**
Cash and cash equivalents at 31 March	20.1	**17,547**	**8,582**

Notes to the Accounts

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the NHS Foundation Trust (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 2021-22 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.

Note 1.2 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 position, 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. More detail on the management assessment of going concern is provided in the annual report.

Note 1.3 NHS Charitable Funds

The Trust is 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 for 2021/22 and are therefore not consolidated.

Note 1.4 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, mainly 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 external performance managers. Accordingly, the Trust operates one segment, 'The provision of healthcare'.

This is in line with management information used within the trust for whom the chief decision maker is the Trust Board.

Note 1.5 Revenue from contracts with customers

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).

The Trust has exercised the practical expedients permitted by IFRS 15 para 121 in preparing the disclosure at note 5. 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 completed to date is not disclosed.

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. In 2021/22 and 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, where funding envelopes are set at an Integrated Care System level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS Providers directly, but the revenue recognition principles are the same. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust also receives additional income outside of the block payments to reimburse specific costs incurred and, in 2020/21, other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In 2021/22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

Revenue from research contracts

Where research contracts fall under IFRS15, 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 distinct good or service, or a series of distinct goods or services that are substantially the same and 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 performance obligations are satisfied. In practical terms this means that treatment has been given, 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.

Revenue from sale of non-current assets

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. No income from the sale of non-current assets was recognised in 2021/22.

Note 1.6 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.7 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy 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 two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The schemes are not designed to be run in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The 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 included at note 9.

National Employees Savings Trust (NEST)

The Trust participates in the National Employees Savings Trust (NEST) scheme as an alternative to those employees who are not eligible to join the NHS Pension Scheme. This was part of the auto enrolment requirements introduced by the Government.

NEST is a defined contribution scheme with a phased employer contribution rate which was 3% for 2021/22. The rate remains at 3% from April 2022.

Note 1.8 Expenditure on other goods and services

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

Note 1.9 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
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar 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 the 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 lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

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.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis
- Non operational properties, including surplus land, are carried at open market value.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

The freehold property known as the Queen Victoria Hospital NHS Foundation Trust was valued as at 31 March 2022 by an external valuer, Gerald Eve LLP, a regulated firm of Chartered Surveyors. The valuation was prepared in accordance with the requirements of the RICS Valuation – Global Standards 2022 and the national standards and guidance set out in the UK national supplement (November 2018), the International Valuation Standards, and IFRS as adapted and interpreted by the Financial Reporting Manual (FReM). The valuations of specialised properties were derived using the Depreciated Replacement Cost (DRC) method.

The Trust has entered into an agreement to sell approximately 1.5 hectares of surplus land which currently forms part of the hospital site. Because the whole site is valued on a modern equivalent asset, alternate site basis, this land is not included in the valuation and is therefore considered to have no value for the purposes of these accounts.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

Land and buildings are held in the Statement of Financial Position at the revalued amounts less any subsequent accumulated depreciation and impairment losses.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

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

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

Revaluation gains and losses

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

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

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

Impairments

At each financial year end, the Trust checks whether there is any indication that its property, plant and equipment or intangible assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of 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. An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is 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.Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as ‘held for sale’ once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

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

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

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

In 2020/21 this includes assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

Useful lives of property, plant and equipment

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

Freehold land is considered to have an infinite life and is not depreciated. Estimated useful lives for buildings are advised to the Trust by an independent valuation expert and currently range from five to 81 years.

Estimated useful lives for plant, machinery and medical equipment are generally three to fifteen years depending on the nature and likelihood of technical obsolescence. Information Technology equipment is generally given a life of four to 25 years.

Finance-leased assets (including land), are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.10 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; where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

Internally generated intangible assets

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

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

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 current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

Amortisation and useful lives

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits. In the case of software licenses, estimated useful life is generally four to seven years

Note 1.11 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

In 2020/21 and 2021/22, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.12 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.

Note 1.13 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM 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.

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, ie, when receipt or delivery of the goods or services is made.

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

Financial assets are classified as subsequently measured at amortised cost

Financial liabilities are classified as subsequently measured at amortised cost

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income as a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses in respect of Trade Receivables are determined by reference to debt history and identified trends. Expected credit losses in respect of Injury Compensation Scheme receivables are calculated using the DHSC national average of claims not reaching payment of 23.76% (2020-21 22.43%).

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 estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

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

Note 1.14 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.

The trust as a lessee

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 as 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

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the Statement of Financial Position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

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.

The trust as a lessor

A lessor shall classify each of its leases as an operating or finance lease. A lease is classified as a finance lease when the lease substantially transfers all the risks and rewards incidental to ownership of an underlying asset. Where substantially all the risks and rewards are not transferred, a lease is classified as an operating lease.

For this Trust, 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 amount of the leased asset, and recognised as an expense on a straight line basis over the lease term.

Note 1.15 provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount, as a result of a past event, for which it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised in the Statement of Financial Position is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2022.

Early retirement provisions are discounted using HM Treasury’s pension discount rate of negative 1.30% (2020-21: negative 0.95%) 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 minus 0.47% (2020-21: negative 0.02%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

- A nominal medium-term rate of 0.70% (2020-21: 0.18%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

- A nominal long-term rate of 0.95% (2020-21: 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

- A nominal very long-term rate of 0.66% (2020-21: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

Note 1.16 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 25.2 but is not recognised in the Trust's accounts.

Note 1.17 Non-clinical risk pooling

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

Note 1.18 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. The Trust has no contingent assets or liabilities to disclose for 2021/22.

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.

Note 1.19 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.

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, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

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 calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.20 Value added tax

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

Note 1.21 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.

In determining if 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 is currently incurred by the Trust.

Note 1.22 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.23 Foreign exchange

The functional and presentational currency of the Trust is 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.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

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

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

Note 1.24 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Amounts held by the Trust at the balance sheet date were negligible.

Note 1.25 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.

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.

Note 1.26 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.

Note 1.27 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

Note 1.28 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases
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 2022. 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 remeasurement 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 2022, the Trust will apply the standard retrospectively without restatement and 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. For 2022 this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, 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 has estimated the impact of applying IFRS16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	-
Additional lease obligations recognised for existing operating leases	20
Changes to other statement of financial position line items	(20)
Net impact on net assets on 1 April 2022	**-**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	-
Additional finance costs on lease liabilities	(10)
Lease rentals no longer charged to operating expenditure	(0)
Other impact on income/expenditure	10
Estimated impact on surplus / deficit in 2022/23	**(0)**
Estimated increase in capital additions for new leases commencing in 2022/23	**20**

Other standards, amendments and interpretations

IFRS 17 Insurance Contracts - Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM. Early adoption is therefore not permitted.

Note 1.29 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

For 2021/22 the Trust has identified the following critical judgements that are required to be disclosed under IAS1 paragraph 122.

- **Going Concern**

The financial statements have been prepared on a going concern basis as set out in note 1.2. In preparing the financial statements the directors have considered the Trust's overall financial position and the continued provision of service.

- **Valuation of land and buildings**

The Trust has applied the concept of Modern Equivalent Asset (MEA) to estimate the valuation of its property assets, as applicable, under the guidance of the DHSC GAM and independent professional valuers. This may result in impairment costs or reversals falling to be recognised in reserves or the income and expenditure statement as appropriate.

- **Charitable Funds**

The Trust continues to make the judgement that the Charitable Funds are not material for the Trust and have not been consolidated.

Note 1.30 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- **Valuation of land and buildings £45,987,000 (2020/21 £43,276,000)**

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.

- **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 25

Note 2 Operating segments

The Trust operates a single segment, the provision of healthcare

	2021/22	2020/21
	£000	£000
Income	86,991	85,151
Segment surplus (deficit)	1,918	3,017
Segment net assets	59,579	52,059

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.5

Note 3.1 Income from patient care activities (by nature)	2021/22	2020/21
	£000	£000
Eyes	8,524	7,314
Oral	15,973	13,705
Plastics	38,899	33,375
Sleep	6,563	5,631
Other	12,450	10,761
Total	**82,409**	**70,786**

Note 3.2 Income from patient care activities (by source)

	2021/22	2020/21
Income from patient care activities received from:	**£000**	**£000**
NHS England *	26,033	25,732
Clinical Commissioning Groups	53,271	42,326
Other NHS providers	1,557	1,765
Non-NHS: private patients	195	190
Non-NHS: overseas patients (chargeable to patient)	7	31
Injury cost recovery scheme **	156	236
Non NHS: other	1,190	506
Total income from activities	**82,409**	**70,786**

Additional note reference note 3 (above)

*The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have 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. £2,202,000 has been included in the NHS England line (2020/2021 £2,097,000)

** 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 23.76% (2020/21 22.43%) to reflect expected rates of recovery

Commissioner requested services

Within the 2020/21 financial statements, management have taken the view that commissioner requested services are those which are provided for the healthcare of NHS patients. Of the total income reported above, £82,489,000 (2020/21 £70,565,000) was derived from the provision of commissioner requested services, being all income except that associated with private and overseas patients.

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2021/22	2020/21
	£000	£000
Income recognised this year	7	31
Cash payments received in-year	18	23
Amounts added to provision for impairment of receivables	5	79

Note 4 Other operating income

	2021/22		
	Contract income	Non-contract income	Total
	£000	£000	£000
Research and development	279	-	**279**
Education and training	1,852	-	**1,852**
Non-patient care services to other bodies	466	-	**466**
Reimbursement and top up funding	859	-	**859**
Receipt of capital grants and donations	-	-	**-**
Charitable and other contributions to expenditure	-	314	**314**
Other income	812	-	**812**
Total other operating income	**4,268**	**314**	**4,582**

	2020/21		
	Contract income	Non-contract income	Total
	£000	£000	£000
Research and development	218	-	**218**
Education and training	1,640	-	**1,640**
Non-patient care services to other bodies	5,543	-	**5,543**
Reimbursement and top up funding	4,394	-	**4,394**
Receipt of capital grants and donations	-	254	**254**
Charitable and other contributions to expenditure	-	2,087	**2,087**
Other income	229	-	**229**
Total other operating income	**12,024**	**2,341**	**14,365**

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2021/22	2020/21
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	304	175

Note 5.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2022 £000	31 March 2021 £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.

Note 6 Operating expenses

	2021/22	2020/21
	£000	£000
Purchase of healthcare from non-NHS and non-DHSC bodies	1,271	181
Staff and executive directors costs	56,815	54,625
Remuneration of non-executive directors	114	113
Supplies and services - clinical (excluding drugs costs)	12,454	12,319
Supplies and services - general	678	707
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	1,392	1,139
Inventories written down	9	236
Consultancy costs	-	32
Establishment	824	771
Premises	3,780	4,339
Transport (including patient travel)	322	335
Depreciation on property, plant and equipment	3,661	3,193
Amortisation on intangible assets	514	367
Net impairments	(674)	(232)
Movement in credit loss allowance: contract receivables / contract assets	(150)	54
Change in provisions discount rate(s)	31	36
Audit fees payable to the external auditor		
audit services- statutory audit *	100	71
other auditor remuneration (external auditor only)	-	-
Internal audit costs	74	79
Clinical negligence	858	838
Legal fees	10	29
Insurance	34	44
Research and development	240	221
Education and training	191	100
Rentals under operating leases	23	-
Car parking and security	351	241
Other services, e.g. external payroll	161	134
Other	483	768
Total	**83,566**	**80,740**

Notes:

External Audit: The contract change agreement effective date 20/10/2021 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 2021/22 was £83,334 exclusive of VAT (2020/21 £59,435).

Note 7 Impairment of assets

	2021/22	2020/21
	£000	£000
Changes in market price	(674)	(232)
Total net impairments charged to operating surplus / deficit	**(674)**	**(232)**
Impairments charged to the revaluation reserve	748	171
Total net impairments	**74**	**(61)**

Note 8 Employee benefits

	2021/22 Total £000	2020/21 Total £000
Salaries and wages	44,403	42,957
Social security costs	4,411	4,178
Apprenticeship levy	205	193
Employer's contributions to NHS pensions	7,241	6,882
Pension cost - other	15	15
Termination benefits	50	-
Temporary staff (including agency)	1,308	1,055
Total staff costs	**57,633**	**55,280**
Of which		
Costs capitalised as part of assets	581	434
Total Staff Costs Excluding capitalised costs	**57,052**	**54,846**

*The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have 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. £2,202,000 has been included in the NHS England line (2020/21 £2,097,000).

More detailed staff disclosures may be found in the Annual Report.

Note 8.1 Retirements due to ill-health

During 2021/22 there were no early retirements from the Trust agreed on the grounds of ill-health (1 in the year ended 31 March 2021). The estimated additional pension liabilities of these ill-health retirements is 0k (£30k in 2020/21).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension 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 for Health and Social Care 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 2022, is based on valuation data as at 31 March 2021, updated to 31 March 2022 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% of pensionable pay. The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pension website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports

National Employees Savings Trust (NEST)

The Trust participates in the National Employees Savings Trust (NEST) scheme as an alternative to those employees who are not eligible to join the NHS Pension Scheme. This was part of the auto enrolment requirements introduced by the Government.

NEST is a defined contribution scheme with a phased employer contribution rate which was 3% for 2020/21. The rate remains at 3% from April 2021.

Note 10 Operating leases

Note 10.1 Queen Victoria Hospital NHS Foundation Trust as a lessor

The Trust has no significant operating leases to disclose for 2021/22

Note 10.2 Queen Victoria NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Queen Victoria Hospital NHS Foundation Trust is the lessee.

	2021/22	2020/21
Lease payments recognised as an expense in year	**£000**	**£000**
Minimum lease payments	23	0
Total	**23**	**-**

	2021/22	2020/21
	£000	**£000**
Future minimum lease payments due;		
not later than one year	23	0
later that one year and not later than five years	27	0
later than five years	0	0
Total	**50**	**-**

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2021/22	2020/21
	£000	**£000**
Interest on bank accounts	6	1
Total finance income	**6**	**1**

Note 12.1 Finance expenditure

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

	2021/22	2020/21
	£000	**£000**
Interest expense:		
Loans from the Department of Health and Social Care	108	130
Finance leases	2	4
Interest on late payment of commercial debt	-	-
Total interest expense	**110**	**134**
Unwinding of discount on provisions	(9)	(7)
Total finance costs	**101**	**127**

Note 13 Other gains / (losses)

	2021/22	2020/21
	£000	£000
Gains on disposal of assets	-	-
Total gains / (losses) on disposal of assets	**-**	**-**

Note 14.1 Intangible assets - 2021/22

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2021 - brought forward	**4,232**	**124**	**4,356**
Additions	1,224	477	**1,701**
Disposals/de-recognition	(1,512)	-	**(1,512)**
Valuation/gross cost at 31 March 2022	**3,944**	**601**	**4,545**
Amortisation at 1 April 2021 - brought forward	**2,126**	**-**	**2,126**
Provided during the year	514	-	**514**
Disposal/de-recognition	(1,512)	-	**(1,512)**
Amortisation at 31 March 2022	**1,128**	**-**	**1,128**
Net book value at 31 March 2022	**2,816**	**601**	**3,417**
Net book value at 1 April 2021	**2,106**	**124**	**2,230**

Note 14.2 Intangible assets - 2020/21

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2020	**2,912**	**1,126**	**4,038**
Additions	242	180	**422**
Reclassifications	1,078	(1,078)	**-**
Valuation/gross cost at 31 March 2021	**4,232**	**124**	**4,356**
Amortisation at 1 April 2020	**1,759**	**-**	**1,759**
Provided during the year	367	-	**367**
Amortisation at 31 March 2021	**2,126**	**-**	**2,126**
Net book value at 31 March 2021	**2,106**	**124**	**2,230**
Net book value at 1 April 2020	**1,153**	**1,126**	**2,279**

Note 15.1 Property, plant and equipment - 2021/22

	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2021 - brought forward	**4,280**	**48,980**	**349**	**17,167**	**9,145**	**79,921**
Additions	-	1,166	3,507	658	213	**5,544**
Impairments	-	(981)	-	-	-	**(981)**
Reversals of impairments	-	907	-	-	-	**907**
Revaluations	150	2,609	-	-	-	**2,759**
Reclassifications	-	297	(345)	-	48	**-**
Disposals/derecognition	-	-	-	-	(1,574)	**(1,574)**
Valuation/gross cost at 31 March 2022	**4,430**	**52,978**	**3,511**	**17,825**	**7,832**	**86,576**
Accumulated depreciation at 1 April 2021 - brought forward	**-**	**9,984**	**-**	**13,555**	**4,447**	**27,986**
Provided during the year	-	1,437	-	1,042	1,182	**3,661**
Disposals/derecognition	-	-	-	-	(1,574)	**(1,574)**
Accumulated depreciation at 31 March 2022	**-**	**11,421**	**-**	**14,597**	**4,055**	**30,073**
Net book value at 31 March 2022	**4,430**	**41,557**	**3,511**	**3,228**	**3,777**	**56,503**
Net book value at 1 April 2021	**4,280**	**38,996**	**349**	**3,612**	**4,698**	**51,935**

Note 15.2 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020	**3,960**	**47,458**	**625**	**16,036**	**7,637**	**75,716**
Additions	-	729	436	1,679	1,110	**3,954**
Impairments	-	(209)	-	-	-	**(209)**
Reversals of impairments	178	92	-	-	-	**270**
Revaluations	142	700	-	-	-	**842**
Reclassifications	-	210	(608)	-	398	**-**
Disposals/derecognition	-	-	(104)	(548)	-	**(652)**
Valuation/gross cost at 31 March 2021	**4,280**	**48,980**	**349**	**17,167**	**9,145**	**79,921**
Accumulated depreciation at 1 April 2020	**-**	**8,590**	**-**	**13,179**	**3,572**	**25,341**
Provided during the year	-	1,394	-	924	875	**3,193**
Disposals/derecognition	-	-	-	(548)	-	**(548)**
Accumulated depreciation at 31 March 2021	**-**	**9,984**	**-**	**13,555**	**4,447**	**27,986**
Net book value at 31 March 2021	**4,280**	**38,996**	**349**	**3,612**	**4,698**	**51,935**
Net book value at 1 April 2020	**3,960**	**38,868**	**625**	**2,857**	**4,065**	**50,375**

Note 15.3 Property, plant and equipment financing - 2021/22

	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2022						
Owned - purchased	4,430	37,514	3,511	2,589	3,761	**51,805**
Finance leased	-	2,032	-	-	-	**2,032**
Owned - donated/granted	-	2,011	-	520	16	**2,547**
NBV total at 31 March 2022	**4,430**	**41,557**	**3,511**	**3,109**	**3,777**	**56,384**

Note 15.4 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021						
Owned - purchased	4,280	35,163	349	2,616	4,676	**47,084**
Finance leased	-	1,909	-	-	-	**1,909**
Owned - donated/granted	-	1,924	-	996	22	**2,942**
NBV total at 31 March 2021	**4,280**	**38,996**	**349**	**3,612**	**4,698**	**51,935**

Note 16 Donations of property, plant and equipment

No capital donations were received by the Trust in 2021/22. (In 2020/21 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 £79,000. The DHSC donated diagnostic equipment valued at £175,000 as part of the response to the Covid-19 pandemic.)

Note 17 Revaluations of property, plant and equipment

Land and buildings were revalued as at 31 March 2022 by professionally qualified, Royal Institute of Chartered Surveyors (RICS) registered, external valuers Gerald Eve LLP (see note 1.9). The valuation took account of changes in market values and work carried out by the Trust since the previous valuation as at 31 March 2021. The remaining useful lives of buildings were also reviewed taking account of the passage of time and maintenance and enhancements carried out by the Trust.

The Trust has entered into an agreement to sell approximately 1.5 hectares of surplus land which currently form part of the hospital site. Because the whole site is valued on a modern equivalent asset, alternate site basis, this land is not included in the valuation and is therefore considered to have no value for the purposes of these accounts.

Note 18 Inventories

	31 March 2022	31 March 2021
	£000	£000
Drugs	160	148
Consumables	994	1,314
Total inventories	**1,154**	**1,462**

Inventories recognised in expenses for the year were £4,341k (2020/21: £4,625k). Write-down of inventories recognised as expenses for the year were £9k (2020/21: £236k).

In response to the Covid 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2021/22 the Trust received £314k of items purchased by DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed in note 6 Operating Expenses.

Note 19.1 Receivables

	31 March 2022	31 March 2021
	£000	£000
Current		
Contract receivables *	2,974	3,921
Allowance for impaired contract receivables / assets	(517)	(1,081)
Prepayments (non-PFI)	707	476
PDC dividend receivable	-	430
VAT receivable	181	99
Other receivables	95	295
Total current receivables	**3,440**	**4,140**
Non-current		
Other receivables **	332	227
Total non-current receivables	**332**	**227**
Of which receivable from NHS and DHSC group bodies:		
Current	1,593	2,892
Non-current	332	227

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

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

Note 19.2 Allowances for credit losses

	2021/22	2020/21
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 April - brought forward	**1,081**	**1,241**
New allowances arising	262	627
Reversals of allowances	(412)	(573)
Utilisation of allowances (write offs)	(414)	(214)
Allowances as at 31 March	**517**	**1,081**

Note 20.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2021/22	2020/21
	£000	£000
At 1 April	**8,582**	**2,910**
Net change in year	8,965	5,672
At 31 March	**17,547**	**8,582**
Broken down into:		
Cash at commercial banks and in hand	243	264
Cash with the Government Banking Service	17,304	8,318
Total cash and cash equivalents	**17,547**	**8,582**

Note 20.2 Third party assets held by the trust

Queen Victoria Hospital NHS Foundation Trust held Nil cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the Trust has no beneficial interest.

Note 21.1 Trade and other payables

	31 March 2022 £000	31 March 2021 £000
Current		
Trade payables	1,801	2,764
Capital payables	4,456	1,338
Accruals	8,796	4,274
Social security costs	654	617
Other taxes payable	604	580
Other payables	1,068	971
Total current trade and other payables	**17,387**	**10,544**
Of which payables from NHS and DHSC group bodies:		
Current	5,718	2,949

Note 22 Other liabilities

	31 March 2022 £000	31 March 2021 £000
Current		
Deferred income: contract liabilities	252	202
Deferred grants	392	229
Total other current liabilities	**644**	**431**

Note 23 Borrowings

	31 March 2022	31 March 2021
	£000	£000
Current		
Loans from DHSC	806	813
Obligations under finance leases	82	80
Total current borrowings	**888**	**893**
Non-current		
Loans from DHSC	2,712	3,489
Obligations under finance leases	83	164
Total non-current borrowings	**2,795**	**3,653**

Note 23.1 Reconciliation of liabilities arising from financing activities - 2021/22

	Loans from DHSC	Finance leases	Total
	£000	£000	£000
Carrying value at 1 April 2021	**4,302**	**244**	**4,546**
Cash movements:			
Financing cash flows - payments and receipts of principal	(778)	(78)	**(856)**
Financing cash flows - payments of interest	(114)	(2)	**(116)**
Non-cash movements:			
Application of effective interest rate	108	2	**110**
Change in effective interest rate	-	(1)	**(1)**
Carrying value at 31 March 2022	**3,518**	**165**	**3,683**

Note 23.2 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	Finance leases	Total
	£000	£000	£000
Carrying value at 1 April 2020	**11,520**	**324**	**11,844**
Cash movements:			
Financing cash flows - payments and receipts of principal	(7,169)	(80)	**(7,249)**
Financing cash flows - payments of interest	(179)	(4)	**(183)**
Non-cash movements:			
Application of effective interest rate	130	4	**134**
Carrying value at 31 March 2021	**4,302**	**244**	**4,546**

Note 24 Finance leases

Note 24.1 Queen Victoria Hospital NHS Foundation Trust as a lessee

Obligations under finance leases where the Trust is the lessee.

	31 March 2022	31 March 2021
	£000	£000
Gross lease liabilities	**167**	**248**
of which liabilities are due:		
- not later than one year;	83	84
- later than one year and not later than five years;	84	164
- later than five years.	-	-
Finance charges allocated to future periods	(2)	(4)
Net lease liabilities	**165**	**244**
of which payable:		
- not later than one year;	82	80
- later than one year and not later than five years;	83	164
- later than five years.	-	-

Note 25.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2021	23	693	31	249	**996**
Change in the discount rate	1	30	-	-	**31**
Arising during the year	6	36	-	112	**154**
Utilised during the year	(6)	(23)	(11)	-	**(40)**
Reversed unused	-	-	(10)	(22)	**(32)**
Unwinding of discount	-	(9)	-	-	**(9)**
At 31 March 2022	**24**	**727**	**10**	**339**	**1,100**
Expected timing of cash flows:					
- not later than one year;	6	29	10	**7**	**52**
- later than one year and not later than five years;	17	115	-	**13**	**145**
- later than five years.	1	583	-	**319**	**903**
Total	**24**	**727**	**10**	**339**	**1,100**

The provisions for pensions represent the discounted value of annual payments made to the NHS Pensions Agency calculated on an actuarial basis

Legal claims are relating to third party and employer's liabilities. Where the case falls within the remit of the risk pooling schemes run by NHS Resolution (formerly NHS Litigation authority), the Trust's liability is limited to an excess of £3,000 or £10,000 per case with the remainder born by the scheme. The provision is shown net of any reimbursement due from NHS Resolution.

"Other" provisions relates primarily to the clinicians pension tax scheme which will be funded through the DHSC.

Note 25.2 Clinical negligence liabilities

At 31 March 2022, £755k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Queen Victoria Hospital NHS Foundation Trust (31 March 2021: £1,105k).

Note 26 Contractual capital commitments

	31-Mar-22 £000	31-Mar-21 £000
Property, plant and equipment	1,900	316
Intangible assets	9	-
Total	**1,909**	**316**

Note 27 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. See also policy note 1.13.

All financial assets and liabilities are denominated in sterling. Carrying values are taken as a reasonable approximation of fair value.

Note 27.1 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2022	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non-financial assets	2,884	**2,884**
Cash and cash equivalents	17,547	**17,547**
Total at 31 March 2022	**20,431**	**20,431**

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non-financial assets	3,359	**3,359**
Cash and cash equivalents	8,582	**8,582**
Total at 31 March 2021	**11,941**	**11,941**

Note 27.2 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	3,518	**3,518**
Obligations under finance leases	165	**165**
Trade and other payables excluding non-financial liabilities	16,121	**16,121**
Total at 31 March 2022	**19,804**	**19,804**

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	4,302	**4,302**
Obligations under finance leases	244	**244**
Trade and other payables excluding non-financial liabilities	7,891	**7,891**
Total at 31 March 2021	**12,437**	**12,437**

Note 27.3 Maturity of financial assets

All of the Trust's financial assets mature within 1 year.

Note 27.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the Statement of Financial Position which are discounted to present value.

	31 March 2022	31 March 2021
	£000	£000
In one year or less	17,074	8,867
In more than one year but not more than five years	2,948	3,898
In more than five years	-	-
Total	**20,022**	**12,765**

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

Note 28 Losses and special payments

	2021/22		2020/21	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Fruitless payments and constructive losses	1	1	1	7
Bad debts and claims abandoned	42	262	-	-
Total losses	**43**	**263**	**1**	**7**
Special payments				
Overtime corrective payments (nationally funded)	1	23	-	-
Ex-gratia payments	11	1	10	1
Total special payments	**12**	**24**	**10**	**1**
Total losses and special payments	**55**	**287**	**11**	**8**

Note 29 Events after the reporting date

No significant events have been identified.

Note 30 Related parties

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 2021/22, (2020/21: 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 of the charity for the year are shown below.

	2021/22		2020/21	
	Income	**Expenditure**	Income	Expenditure
	£000	**£000**	£000	£000
The Queen Victoria Hospital NHS Trust Charitable Fund	**144**	**0**	120	0

Receivables and payables relating to the charity at 31 March 2022 were:

	31 March 2022		31 March 2021	
	Receivable	**Payable**	Receivable	Payable
	£000	**£000**	£000	£000
The Queen Victoria Hospital NHS Trust Charitable Fund	**157**	**1**	208	0

Whole of Government Accounts bodies with significant transactions (over £500k)

	2021/22		**2020/21**		**2021/22**		**2020/21**	
Income, Expenditure, Receivables and Payables	**Income**	**Expenditure**	**Income**	**Expenditure**	**Receivables**	**Payables**	**Receivables**	**Payables**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**

University Hospitals Sussex NHS Foundation Trust (formally Western Sussex Hospitals NHS Foundation Trust acquired Brighton and Sussex University Hospital NHS Trust on 1 April 2021) Comparatives restated	**851**	**1,318**	728	837		**497**	**429**	226	389	
Dartford and Gravesham NHS Trust	**-**	**519**	-	446		**-**	**5**	-	229	
Medway NHS Foundation Trust	**98**	**1,145**	72	801		**99**	**507**	72	716	
East Sussex Healthcare NHS Trust	**2**	**461**	2	554		**-**	**68**	-	269	
NHS Resolution	**-**	**858**	-	838		**-**	**-**	-		-
Health Education England	**1,851**	**-**	1,603	-		**-**	**-**	996		-
NHS England	**24,914**	**-**	28,982	-		**413**	**-**	510		-
NHS Brighton & Hove CCG	**1,895**	**-**	1,508	1		**-**	**-**	-		-
HM Revenue and Customs (employer national insurance and apprenticeship levy)	**-**	**4,616**	-	4,371		**-**	**1,258**	-	1,197	
NHS Pension Scheme (employer contributions)	**-**	**7,241**	-	6,897		**-**	**746**	-	688	
NHS South East London CCG	**1,222**	**1**	1,194	-		**-**	**-**	15		-
NHS Surrey Heartlands CCG	**4,976**	**-**	5,012	-		**-**	**-**	23		-
NHS East Sussex CCG	**12,561**	**44**	10,307	850		**6**	**4,292**	52	843	
NHS Kent and Medway CCG	**14,505**	**-**	14,138	4		**7**	**-**	49		-
NHS West Sussex CCG	**18,112**	**11**	14,424	-		**-**	**-**	5		-
	80,763	**16,214**	**77,970**	**15,599**		**798**	**7,305**	**1,948**	**4,331**	

APPENDIX 6.1 Board of directors register

Name, title and appointment	Member attendance 2021/22						
	Board of directors	**Audit committee**	**Nomination and remuneration committee**	**Finance and performance committee**	**Quality and governance committee**	**Council of governors**	**QVH Charity**
Keith Altman Medical Director 1 October 2019 to 16 January 2022	5 of 6 (member)	NA	NA	NA	4 of 7 (member)	NA	3 of 3 (member)
Lawrence Anderson + Interim Director of Workforce and Organisational Development 10 June 2021 to present	5 of 5 (member)	NA	NA	10 of 10 (member)	6 of 7 (member)	NA	NA
Tania Cubison Medical Director 19 January 2022 to present	1 of 1 (member)	NA	NA	NA	1 of 1 (member)	NA	0 of 1 (member)
Paul Dillon- Robinson Non-Executive director 1 October 2019 to 30 September 2022	7 of 7 (member)	6 of 6 (member)	4 of 4 (member)	12 of 12 (chair)	NA	NA	NA
Anita Donley Trust Chair 15 November 2021 to present	2 of 2 (chair)	NA	2 of 2 (chair)	4 of 6 (member)	NA	2 of 2 (chair)	0 of 2 (member)
Kevin Gould Non-Executive director 1 September 2020 to 30 August 2023	7 of 7 (member)	6 of 6 (chair)	3 of 4 (member)	10 of 12 (member)	NA	NA	NA
Beryl Hobson Trust Chair Reappointed 1 April 2021 to 30 September 2021	4 of 4 (chair)	NA	1 of 1 (chair)	4 of 5 (member)	NA	3 of 3 (chair)	2 of 2 (member)
Steve Jenkin Chief Executive 14 November 2016 to present	7 of 7 (member)	NA	NA	12 of 12 (member)	7 of 8 (member)	NA	NA
Abigail Jago + Director of Operations 8 May 2018 to 6 March 2022	6 of 7 (member)	NA	NA	9 of 11 (member)	4 of 8 (member)	NA	NA

Gary Needle Non-Executive Director 1 July 2020 to 30 June 2023, and senior independent director since 1 October 2019	7 of 7 (member)	NA	4 of 4 (member)	NA	7 of 8 (member)	NA	3 of 4 (chair)
Michelle Miles Director of Finance and Performance 1 February 2018 to present	7 of 7 (member)	NA	NA	11 of 12 (member)	6 of 8 (member)	NA	3 of 4 (member)
Shane Morrison- McCabe + Director of Operations 21 March 2022 to present	0 of 0 (member)	NA	NA	2 of 2 (member)	0 of 0 (member)	NA	NA
Karen Norman Non-Executive Director Reappointed 8 April 2022 to 8 April 2025	7 of 7 (member)	3 of 6 (member)	4 of 4 (member)	NA	7 of 8 (chair)	NA	NA
Geraldine Opreshko + Director of Workforce and Organisational Development 26 July 2017 to 9 June 2021	1 of 2 (member)	NA	NA	2 of 2 (member)	1 of 1 (member)	NA	NA
Clare Pirie + Director of Communications and Corporate Affairs 1 May 2017 to present	6 of 7 (member)	NA	NA	NA	NA	NA	NA
Nicky Reeves Chief Nurse 12 November 2020 to present	7 of 7 (member)	NA	NA	NA	8 of 8 (member)	NA	NA

+ denotes non-voting executive member of the board

APPENDIX 6.2 Council of governors register 2021/22

Name	Constituency	Status of current term	Start of term	End of term	Meeting attendance
Barham, Chris	Public	Elected 1st term	01/02/2021	30/06/2023	9 of 10
Beesley, Brian	Public	Elected 1st term	01/07/2018	30/06/2021	2 of 2
Bennett, Liz	Stakeholder[1]	Re appointed	01/05/2017	30/04/2025	6 of 10
Bowden, Elizabeth	Public	Elected 1st term	01/02/2021	30/06/2023	7 of 10
Brown, Andrew	Public	Elected 1st term	01/02/2021	30/06/2023	8 of 10
Brown, St John	Stakeholder[2]	Re appointed	01/04/2020	31/03/2023	7 of 10
Butler, Tim	Public	Elected 1st term	01/02/2021	30/06/2023	10 of 10
Dheansa, Balj	Staff	Elected 1st term	01/02/2021	30/06/2023	9 of 10
Farley, Miriam	Public	Elected 1st term	01/02/2021	30/06/2023	6 of 10
Fulford-Smith, Antony	Public	Re-elected 2nd term	01/02/2021	30/06/2023	10 of 10
Haite, Janet	Public	Re-elected 2nd term	01/02/2021	30/06/2023	8 of 10
Halloway, Chris	Public	Re-elected 2nd term	01/07/2018	30/06/2021	2 of 2
Harley, Oliver	Public	Elected 1st term	01/02/2021	30/06/2023	9 of 10
Harold, John	Public	Elected 1st term	01/07/2019	30/06/2022	10 of 10
Hazari, Anita	Staff	Elected 1st term	01/02/2021	30/06/2023	9 of 10
Holden, Julie	Stakeholder[3]	Appointed	06/01/2020	05/01/2023	5 of 10
Lane, Andrew	Public	Elected 1st term	01/07/2018	30/06/2021	2 of 2
Malhotra, Raman	Staff	Elected 1st term	01/02/2021	30/06/2023	3 of 10
Migo, Caroline	Public	Elected 1st term	01/02/2021	30/06/2023	10 of 10
Shore, Peter[4]	Public	Re-elected 2nd term	01/07/2019	30/06/2022	10 of 10
Smith, Roger	Public	Elected 1st term	01/02/2021	30/06/2023	9 of 10
Sim, Ken	Public	Elected 1st term	01/02/2021	30/06/2023	9 of 10
Stewart, Alison	Public	Elected 1st term	01/02/2021	30/06/2023	7 of 10
Ward Booth, Peter	Public	Elected 1st term	01/02/2021	30/06/2023	10 of 10
Williams, Martin	Public	Elected 1st term	01/07/2018	30/06/2021	2 of 2
Yoganathan, Thavamalar	Public	Elected 1st term	01/02/2021	30/06/2023	9 of 10

[1] Representing West Sussex County Council
[2] Representing QVH League of Friends
[3] Representing East Grinstead Town Council
[4] Lead Governor since August 2019

APPENDIX 6.3 Directors' biographies 2021/22

Lawrence Anderson, interim Director of Workforce and Organisational Development
Lawrence Anderson was appointed interim director of workforce and organisational development in June 2021, having previously been the Trust's deputy director of workforce. Lawrence has worked in the NHS since 2004 and began his career as a Band 4 HR Officer at Maidstone and Tunbridge Wells NHS Trust. Lawrence has a strong background in Medical HR and has previously worked in district general hospitals and large acute NHS organisations, both in London and the South East, across a number of different disciplines within HR. Lawrence's particular interests lie in understanding how workforce and organisational development can support and work with managers and staff to add value and ensure we are able to provide the best care to both our staff and our patients.

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 and diploma of legal medicine. 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 at 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. Keith stepped down as medical director on 16 January 2022.

Tania Cubison, Medical Director
Tania Cubison is a military plastic surgeon who first joined Queen Victoria Hospital as an SHO in 1996, progressing to consultant, before her appointment as Medical Director in January 2022. Tania is a regular Lieutenant Colonel and retains an operational role. Tania underwent specialist registrar training in West Sussex and Newcastle, was awarded the McGregor Gold medal for the FRCS (Plast) examination in 2006, and completed a specialist burn fellowship at Chelmsford. She continues to provide acute burns care and specialises in the surgical management of amputees, including the new technique of targeted muscle reinnervation for phantom limb pain. Tania is QVH safeguarding lead, an active member of the British Burns Association, and is currently the chair of the Senate for the Emergency Management of Severe Burns in the UK. Tania is especially interested in human factors such as teamwork and communication, and their contribution to patient safety.

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.

Anita Donley, interim Trust Chair
Dr Anita Donley OBE is a consultant physician in acute medicine by background and joined Queen Victoria Hospital as Chair in November 2021. She has worked for over 20 years contributing to strategy and policy in healthcare at a national level including patient safety and quality of care, clinical standards and outcomes, implementation and evaluation; medical education and training; health promotion, nutrition; and

environmental toxicity. She has been a member of several national regulatory, advisory, academic and non-departmental public bodies and has worked at Board level in several settings, including chairing a statutory committee for a regulator.

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) since 1998, where he is a parish councillor. He 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. Beryl Hobson stepped down as Chair of QVH on 30 September 2021.

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 left QVH on 20 March 2022.

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 over 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 how all staff can help reduce wastage and improve efficiency.

Shane Morrison-McCabe, Director of operations (non-voting)
Shane joined QVH on 21 March 2022. She has more than 36 years working in the NHS and a clinical background in health visiting and nursing. Shane joined QVH from Medway Maritime Hospital in Kent where she was director of operations - urgent and integrated care since April 2021. Previously Shane was deputy chief operating officer - urgent care at East Sussex NHS Healthcare Trust between March 2020 and November 2021, and for five years was deputy chief operating officer and divisional director for integrated medicine at Bedford Hospital.

Gary Needle, Non-Executive Director and 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 and currently serves as a consultant advisor to the Minister of Health in Qatar. Gary is chair of the board of trustees at East Grinstead Sports Club. At QVH, Gary chairs the charity committee and sits on the quality and governance committee. He was appointed to the role of senior independent director in October 2019.

Karen Norman, Non-Executive Director
Karen joined the board in April 2019 and lives in Brighton. She chairs the quality and governance committee and is a member of the audit committee. Karen 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, and as an independent consultant, mostly in Scandinavia. 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. Geraldine retired from the NHS on 9 June 2021.

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 is the Company Secretary for QVH and is responsible for development of the QVH Charity, as well as strategic leadership for communications and engagement.

Nicky Reeves, Chief Nurse
Nicky Reeves was appointed interim director of nursing and quality in November 2020, having previously been the deputy director of nursing at QVH for five years. She was made substantive Chief Nurse in February 2022. Nicky trained at the Hammersmith Hospital and has 36 years of nursing experience. She has held a range of posts at QVH and other trusts across Surrey and Kent, leading and managing services at senior management level as well as having extensive operational nursing experience. Nicky has always had a specialist interest in surgical nursing and started her QVH career 15 years ago as the Burns Centre Manager. Nicky is passionate about ensuring the patients who use our services get great care. Living locally, Nicky is well aware of the importance of QVH to the population of East Grinstead.

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

Queen Victoria Hospital
NHS Foundation Trust
Holtye Road
East Grinstead
West Sussex RH19 3DZ

T : 01342 414000
E : qvh.info@nhs.net
W: www.qvh.nhs.uk