Queen Victoria Hospital
NHS Foundation Trust

Annual Report, Quality Accounts and Financial Accounts **2014/15**

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

Contents

1 Introduction

1.1 Chair's introduction

I am pleased to present the 2014/15 annual report, quality accounts and financial accounts for Queen Victoria Hospital NHS Foundation Trust.

In 2014/15 QVH continued to provide care that is regarded by patients as amongst the best in the country. In March 2015 99% of inpatients said they were extremely likely/likely to recommend QVH to their friends and family. We put patients at the heart of safe, compassionate and competent care. So we are proud to report that patients' experience of our hospital and its services is outstanding.

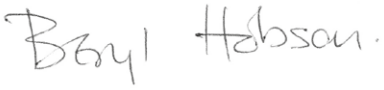
However, we cannot rest on our laurels. Over the past year we developed our long-term strategic plan – *QVH 2020* – to be clear about and focused on the kind of NHS organisation we want to be in five years' time. These key strategic objectives have shaped the ways in which we have restructured our organisation this year. Working with our staff, we made important changes to our structure and leadership team. As a result we are poised to tackle the challenges and seize the opportunities we will encounter.

The extent of the challenges faced by the NHS in 2014/15 has been unprecedented. As an NHS foundation trust we are one of very few that generated the surplus we planned to make. This achievement is exceptional in its context but also vital to QVH. Our surplus enables us to make significant investment in our infrastructure and estate. In turn these investments help us realise our ambitions to deliver world-class clinical services in an environment that meets the needs of patients and their families.

We could not face the future with optimism without the support of our council of governors and the strong working relationship which continued in 2014/15 between the council and the board of directors.

Both the council and board have been led for the past ten years by Peter Griffiths CBE who retired as chairman of the trust on 31 March 2015. On behalf of the trust I would like to pay tribute to Peter's talented leadership and dedication to QVH which were appreciated by all who worked with him. Like many eminent figures who have helped to shape QVH over the years, Peter contributed to a powerful legacy that continues to guide our organisation as we look ahead.

As I take over as chair of the trust, I am mindful of our reputation for innovative, high-quality care and the pride that our staff share in our achievements, past and present. I am excited about the potential for us to grow our specialist services and improve the way we do things at our main hospital site and at other sites across our region. Along with my colleagues, I am equally focused on the opportunities for us to offer more to our local community and to collaborate with other providers. Local people and networks have been instrumental to our success and I look forward to leading QVH in partnership with them.



Beryl Hobson
Chair

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Strategic report

2.1 A brief history of the foundation trust

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

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

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

QVH was authorised as one of the country's first NHS foundation trusts in July 2004. We have around 8,000 public members in Kent, Surrey and Sussex.

2.2 Review of the foundation trust's business

Business model

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

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

In 2014/15, the principal activities of the trust were the provision of:

- reconstructive surgery (head and neck, maxillofacial, corneoplastic, oculoplastic, general plastic, oncoplastic and trauma)
- rehabilitation therapy
- burns care
- community medical services (outreach therapy services and minor injuries unit).

QVH operates from its 'hub' hospital site in East Grinstead, West Sussex. Reconstructive surgery services are also provided by QVH in 'spoke' facilities at other hospital sites across Kent, Surrey and Sussex – in particular at East Surrey Hospital, Royal Sussex County Hospital, Princess Royal Hospital in Haywards Heath, Royal Alexandra Children's Hospital in Brighton, Medway Maritime Hospital, Darent Valley Hospital, Maidstone Hospital, Eastbourne District General Hospital, William Harvey Hospital in Ashford, Tunbridge Wells Hospital in Pembury, Kent and Canterbury Hospital in Canterbury, Sevenoaks Hospital, Faversham Cottage Hospital and the Conquest Hospital in Hastings.

Strategy

In September 2013 QVH initiated a strategic review entitled *Delivering Excellence: QVH 2020*. The aim of the review was to determine the strategic direction of the trust for the next five to ten years and defined excellence across five domains to establish the trust's key strategic objectives (KSOs):

1 Outstanding patient experience

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

2 World class clinical services

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

3 Operational excellence

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

4 Financial sustainability

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

5 Organisational excellence

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

More information about the trust's strategy in 2014/15 is available from:

- QVH summary strategic plan 2014/15 – 2018/19
  Prepared for Monitor and published in June 2014
  https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/392941/QVH_Publishable_Summary_Strategic_Plan_1415.pdf
- QVH summary annual plan 2014/15
  http://qvh.nhs.uk/assets/publication/QVH%20-%20Annual%20Plan%20Summary%202014-15.pdf
- QVH annual report, quality accounts and financial accounts 2013/14
  Page 16 of the report provides a table which demonstrates how the KSOs are aligned with the board's main responsibilities and priorities in 2014/15
  http://qvh.nhs.uk/assets/publication/AR%202014.pdf

Development and performance of the NHS foundation trust during the financial year

During 2014/15 the trust sought to deliver on its in-year performance targets whilst moving towards its longer-term objectives as outlined in its strategic plan.

The trust achieved its 2014/15 financial plan, delivering its planned surplus of £2.25m. The board was alerted to concerns over lower levels of elective in-patient activity during Q3. A subsequent analysis determined that these were largely the result of short-term capacity constraints resulting from unplanned changes in the consultant body and sickness absence. Whilst these were mitigated to an extent by higher than planned levels of day-case activity, there was a shortfall in planned patient income.

In respect of key performance targets the trust struggled to achieve compliance with the 18-week referral to treatment time (RTT) target during Q1 and Q2. Following discussion with commissioners, a decision was taken to carry out a specific waiting list initiative in November. Additional lists were scheduled for weekends and evenings in order to clear the backlog. The initiative was successful and the trust achieved aggregate compliance for the remainder of the year.

The trust also took significant steps towards its longer-term objectives. The strategic plan identified three areas for development: trauma and burns; hub and spoke services; and community-facing services. The trust has initiated a service review of burns with Brighton and Sussex University Hospitals (BSUH) with the objective of securing a sustainable future for the service. A detailed review of hub and spoke services has been undertaken which has identified significant opportunities for development.

Finally, the trust has developed a strong working relationship with its local GPs around the concept of town-based integrated services. This resulted in a bid to become part of the national 'vanguard' programme piloting new models of integrated care. Whilst the bid was not successful it has helped cement local relationships and work is continuing on the development of local service models.

The position of the business at the end of the financial year

The trust achieved its 2014/15 financial plan, generating a £2.25m surplus. This has put the trust in a strong position for 2015/16. The trust plans to make strategic investments of £800k to support the development of its longer term strategy, as well as investing £2m of capital in upgrading its IT infrastructure, a significant enabler for future productivity plans.

The trust's employees

At the end of the financial year the trust employed 979 individuals of whom 216 are male and 763 are female. It employed three male directors and one female director. Of the other senior managers who report to the chief executive, one is male and two are female.

The staff survey section of this report at page 62 provides more information about how the trust engages with its employees and responds to their feedback.

More information about the trust's workforce is published in board papers on the trust's website which are available in full from: http://qvh.nhs.uk/about_us/board_of_directors/meetings_in_public.php

This review of the foundation trust's business does not include information about environmental matters or social, community and human rights issues.

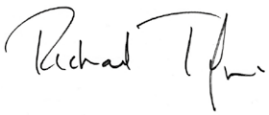
2.3 Principle risks and uncertainties

Throughout 2014/15 the trust has maintained a board assurance framework (BAF) which tracked in detail the principle risks to the achievement of the KSOs and a corporate risk register (CRR) which tracked the risks to the trust's operational activities. Both tools set out the measures in place to mitigate and manage risks and track progress and both were updated and reviewed by the board each quarter. Board papers are published on the trust's website and are available in full from: http://qvh.nhs.uk/about_us/board_of_directors/meetings_in_public.php

2.4 Going concern

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

The accounts have been prepared under a direction issue by Monitor under the National Health Service Act 2006.



Richard Tyler
Chief Executive and Accounting Officer
28 May 2015

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Directors' report

3.1 Companies Act disclosures

In 2014/15 the following individuals served as directors of the trust:

Name	Position
Stuart Butt	Interim Director of Finance and Commerce (9 June 2014 to 12 December 2014)
Ginny Colwell	Non-Executive Director
Steve Fenlon	Medical Director
Peter Griffiths	Chairman
Richard Hathaway	Director of Finance and Commerce (to 9 June 2014)
Beryl Hobson	Non-Executive Director and Chair Designate (from 1 July 2014)
Amanda Parker	Director of Nursing and Quality (to 31 January 2015)
Lester Porter	Senior Independent Director and Non-Executive Director
Jo Thomas	Interim Director of Nursing and Quality (from 2 February 2015)
John Thornton	Non-Executive Director
Dominic Tkaczyk	Interim Director of Finance and Commerce (from 1 December 2014)
Richard Tyler	Chief Executive

Other required disclosures:	
Any political donations should be disclosed	Not applicable.
Any important events since the end of the financial year affecting the NHS foundation trust	Not applicable.
An indication of likely future developments at the NHS foundation trust	Not applicable.
An indication of any significant activities in the field of research and development	In 2014/15: • The board of directors, as corporate trustee of the QVH charity, agreed to extend the secondment of Dr Brian Jones as director of research and development for two more years. • The trust was a joint applicant on 15 grants applications with a combined value in excess of £11 million. • A melanoma special interest research group of academics and clinicians from the trust, the University of Brighton and the Brighton and Sussex Medical School was established. • The trust exceeded its National Institute for Health Research recruitment targets by 60% to secure ongoing funding for research studies.
An indication of the existence of branches outside the UK	Not applicable.

Policies applied during the financial year for giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities	The trust's recruitment and selection policy was updated in 2014/15 following a full equality and human rights impact analysis. The trust uses the guaranteed interview scheme for recruitment which identifies applicants with a disability using the facilities available on the NHS Jobs recruitment website and managers are reminded to interview those applicants providing they meet the essential criteria for the role. Applicants with disabilities who require adjustments to be made to trust equipment or processes are also identified through this 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	Staff who become disabled are supported by their line managers, the occupational health service and, where appropriate, the access to work scheme to enable them to remain in their role. Suitable adjustments are arranged where possible and were made for ten members of staff during 2014/15 which included improving access to work, changes to working hours / duties and obtaining voice recognition software. Redeployment to other roles is also considered with advice from the trust's occupational health service and in line with the trust's sickness policy.
Policies applied during the financial year for the training, career development and promotion of disabled employees	Delivery of training is under regular review as part of the trust's equality objective scheme action plan and the trust works with disabled staff as individuals, discussing their needs on a case-by-case basis. The trust is in the process of re-accreditation as a 'two ticks' disability employer.
Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees	In 2014/15 the trust undertook a major management re-structure aligning services into surgical specialties. This provided opportunities to engage with staff on the proposals and for staff to comment on and influence the final structure. Engagement sessions were led by the chief executive and resulted in a wide range of views being expressed from staff across the trust. The proposals were amended as a result and changes were communicated to staff to demonstrate the impact of their engagement. Monthly staff briefings, fortnightly staff newsletters and regular walk-rounds by members of the executive team allow the trust to communicate and engage with its workforce more generally. In 2014/15 the trust also commissioned the development of a new intranet to support its internal communications.
Actions taken in the financial year to consult employees or 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 interest	Formal consultation with staff is driven through: • Joint consultation and negotiating committee comprising trade union and management representatives • Local negotiating committee involving managers and medical staff representatives and including a British Medical Association representative.
Actions taken in the financial year to encourage the involvement of employees in the NHS foundation trust's performance	Monthly staff briefings are held with an open invitation to all staff and an expectation that managers cascade the briefing to their teams. The agenda focuses on the financial, operational and quality performance of the organisation in the previous month. Feedback from meetings of the board of directors is provided in the staff newsletter each month. Staff are provided with the link to the published meeting papers and can attend the meetings.
Actions taken in the financial year to achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of the NHS foundation trust	In addition to the information provided above, briefings are developed for staff as required by the development of financial and economic factors. They are communicated as part of the staff newsletter or by 'all staff' emails.
In relation to the use of financial instruments, an indication of the financial risk management objectives and policies of the NHS foundation trust and the exposure of the entity to price risk, credit risk, liquidity risk and cash flow risk, unless such information is not material for the assessment of the assets, liabilities, financial position and results of the entity	Not applicable.

3.2 Enhanced quality governance reporting

The quality governance structure in place allows the directors, through trust groups, sub-committees and speciality directorate reviews to regularly seek assurance on the quality of services provided to patients. At these meetings, safety of care is reviewed through reports on incidents, infection control and risks, and mitigating actions identified. Where there are concerns or further assurance is required, formal plans are put in place and reviewed at monthly operational meetings involving the senior managers. Clinical effectiveness is reviewed through reports on cancelled operations, clinical indicators, clinical outcome measures, waiting times for surgery and patient complaints. Patient experience is reviewed through complaints and feedback questionnaires and is further supported by national patient surveys. Where a significant incident or concern occurs or is identified by either the executive team or within a directorate an immediate investigation is undertaken using root cause analysis methodology. Actions are documented and regularly reviewed until completed by the named lead and an additional system of checking that actions have been completed is managed by the trust safety and risk manager. All serious incidents are reported through to the trust board and actions are followed up and monitored through the quality and risk committee.

The quality and risk sub-committee of the board of directors provides assurance on quality matters. Information from a wide range of sources is presented for monitoring and measurement and additional scrutiny may be requested if assurance is partial. The chair of this committee provides a bimonthly update to the board and the clinical cabinet reviews all the key quality information going to the board in an advisory and clinical leadership capacity. The board receives a detailed exception report about quality metrics and safe staffing each month where there is robust challenge from the non-executives.

More detailed references to quality and its three key components of safety, effectiveness and patient experience can be found in the 2014/15 quality report, the directors' report at section 3 above and in papers for the meetings of the board of directors which are available online from the trust's website.

QVH has not participated in a routine inspection or special review by the CQC during 2014/15 and the CQC has not taken enforcement action against QVH. QVH has continued monthly compliance in practice inspections in clinical areas using the CQC domain headings; safe, caring, effective, responsive and well-led in the methodology. A wide range of staff and stakeholders volunteer to undertake the reviews which also provide an opportunity for 'fresh eyes' in these areas.

During 2014/15, a working group has been examining board governance structures with reference to Monitor's 2014 *Well-Led Framework* for governance reviews and the Francis Inquiry findings. An interim report has been presented to the board alongside a list of initial recommendations and a final report will be presented to the board in July 2015 with final recommendations being implemented by October 2015.

3.3 Statement as to disclosure to auditors

For each individual who is a director at the time this annual report was approved, so 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.

3.4 Additional disclosures

Accounting policies for pensions and other retirement benefits are set out in notes 1.2, 7.3 and 9 to the accounts. Details of senior employees' remuneration can be found in section 4.3.2 of the remuneration report.

Queen Victoria Hospital NHS Foundation Trust's company secretary maintains registers of interest of directors and governors which are available for inspection by members of the public on request. The trust's constitution provides more information about the registers, access and exceptions.

The trust is fully compliant with the cost allocation and charging guidance issued by HM Treasury.

Sickness absence data	
Sickness absence 2014/2015	3.4%
Sickness absence days lost	12,120
Sickness absence FTE days lost	10,213

3.5 Statement of directors' responsibilities

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

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Remuneration report

4.1 Annual statement on remuneration

In 2014/15 the nomination and remuneration committee made no changes to the remuneration of the trust's senior managers. The committee also agreed not to introduce performance related pay or bonus payments for senior managers in 2014/15.

Lester Porter
Senior Independent Director
Chairman, Nomination and Remuneration Committee
28 May 2015

4.2 Senior managers' remuneration policy

The trust's approach to remuneration continues to be influenced by nationally-agreed changes. The majority of staff receive pay awards determined by the Department of Health as they are paid according to national terms and conditions, for example Agenda for Change and the pay review bodies for doctors and dentists. In line with Agenda for Change, pay progression is linked with performance and is managed through the appraisal system. Managers are now required to authorise pay increments subject to the satisfactory completion of individual objectives. QVH does not intend to implement separate arrangements for performance related pay or bonuses in the coming financial year.

Senior managers' pay arrangements are subject to approval by the trust's nomination and remuneration committee. In the last 12 months the committee reviewed the national position with regard to pay for health service managers and agreed to hold salaries at their current level. In the year ahead the committee will receive recommendations from the director of human resources based on evidence on health sector pay using IDS reports which cover both NHS and local authority pay for senior managers.

The effectiveness and performance of senior managers is determined through performance appraisal, linked to the trust's *QVH 2020* long-term strategy. This provides five key strategic objectives from which a set of individual objectives has been developed. These will be reviewed through the year by the chief executive to determine progress and achievement. The nomination and remuneration committee has not agreed the introduction of performance related pay or bonus payments for senior managers and does not intend to do so for 2015/16.

The majority of staff - whether on national terms and conditions or local arrangements - are contracted on a permanent, full time or part time basis. Exceptions to this are in positions where it is felt that an individual needs to be recruited on a fixed term contract, or as an off-payroll arrangement, to carry out a specific project which is time limited. This approach enhances control of staffing resources and enables flexibility where this is appropriate to the role.

National guidance on notice periods for Agenda for Change staff is followed and is determined by salary banding. The maximum in such cases is three months' salary and is in line with current employment legislation. Termination payments are made within the contractual rights of the employee and therefore would be subject to income tax and national insurance contributions. This applies to senior managers whose remuneration is set by the nomination and remuneration committee. Where a senior manager receives payment for loss of office this is determined by their notice period and in all cases does not exceed three months.

4.3 Annual report on remuneration

4.3.1 Information not subject to audit

Service contracts

Name	Position	Start date	Term	Notice period
Stuart Butt	Interim Director of Finance	9 June 2014	Temporary	1 month
Stephen Fenlon	Medical Director	1 April 2013	Permanent	3 months
Richard Hathaway	Director of Finance	1 April 2010	Permanent	3 months
Amanda Parker	Director of Nursing and Quality	31 May 2009	Permanent	3 months
Joanne Thomas	Interim Director of Nursing	2 February 2015	Temporary (secondment)	1 month
Dominic Tkaczyk	Interim Director of Finance	1 December 2015	Temporary	1 month
Richard Tyler	Chief Executive Officer	1 June 2013	Permanent	6 months

Remuneration committee

The nomination and remuneration committee met six times in 2014/15 to review and make recommendations to the board of directors on the composition, balance, skill mix and succession planning of the board. Additionally the committee makes recommendations on the appointment of executive directors and is responsible for setting the overall strategy for the remuneration of all staff.

The committee has delegated responsibility for the remuneration packages and contractual terms of the chief executive officer, executive directors and other senior managers reporting to the chief executive.

Details of the membership of the nomination and remuneration committee and of the number of meetings and individuals' attendance at each is disclosed in section 12.1.

The committee was materially assisted in its considerations at all meetings held in 2014/15 by Graeme Armitage, Head of Human Resources and Organisational Development.

In 2014/15 the committee determined and pursued its work programme. Its work was particularly focused on the composition of and recruitment to the senior team led by the chief executive following a process of organisational restructuring and a number of unplanned vacancies.

Disclosures required by the Health and Social Care Act

Directors
Information on the remuneration of the directors and on the expenses of directors is provided in table A of section 4.3.2 below.

Governors
Information on the expenses of the governors is provided as follows:

1 April 2014 to 31 March 2015			1 April 2013 to 31 March 2014		
Total number of governors in office	**Number of governors receiving expenses in 2014/15**	**Aggregate sum of expenses paid in 2014/15 (rounded to the nearest £00)**	**Total number of governors in office**	**Number of governors receiving expenses in 2013/14**	**Aggregate sum of expenses paid in 2013/14 (rounded to the nearest £00)**
31 served for all or part of 2014/15	2	£1,400	25 served for all or part of 2013/14	3	£800

Off-payroll engagements

Senior appointments made on an interim basis are engaged following approval by the nomination and remuneration committee. They are subject to maximum periods of six months and are made in accordance with the regulations set by HMRC. In 2014/15 off-payroll arrangements were made for two senior posts: two consecutive interim appointments to cover the vacant director of finance post and one interim appointment to cover the vacant director of nursing post while active recruitment was undertaken for both posts.

Table 1: All off-payroll engagements as of 31 March 2015, for more than £220 per day and that last for longer than six months

Number of existing engagements as of 31 March 2015	3
Of which...	
Number that have existed for less than one year at the time of reporting	-
Number that have existed for between one and two years at the time of reporting	3
Number that have existed for between two and three years at the time of reporting	-
Number that have existed for between three and four years at the time of reporting	-
Number that have existed for four or more years at the time of reporting	-
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.	Confirmed

Table 2: All new off-payroll engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015, for more than £220 per day and that last for longer than six months

Number of new engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015	0
Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations	-
Number for whom assurance has been requested	-
Of which...	
Number for whom assurance has been received	-
Number for whom assurance has not been received	-
Number that have been terminated as a result of assurance not being received	-

Table 3: Any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2014 and 31 March 2015

Number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during 2014/15	2
Details of the exceptional circumstance that led to each of these engagements	Following the departure of the director of finance and commerce in April 2014, an interim appointment was made while a recruitment process was undertaken. When an appointment could not be made, a second interim appointment was made while a second recruitment process was undertaken.
Details of the length of time each of these exceptional engagements lasted	The first interim was engaged for 5.8 months and the second for 3 months.
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year (off-payroll and on-payroll)	7

4.3.2 Information subject to audit

Salary and pension entitlements of senior managers						
A) Remuneration	**2014/15**					
Name and title	**Salary** (bands of £5,000) £000	**Benefits in kind** Rounded to the nearest £100	**Annual performance-related bonus** (bands of £5,000) £000	**Long-term performance-related bonus** (bands of £5,000) £000	**Pension-related benefits** (bands of £2,500) £000	**Total remuneration** (bands of £5,000) £000
V Colwell (Non-Executive Director)	10-15	800	0	0	0	15-20
S Fenlon (Medical Director)	150-155	100	0	0	65-67.5	215-220
P Griffiths (Chairman)	40-45	700	0	0	0	45-50
R Hathaway (Director of Finance)	10-15	100	0	0	5-7.5	15-20
B Hobson (Chairman)	15-20	600	0	0	0	15-20
A Parker (Director of Nursing and Quality)	75-80	200	0	0	0	75-80
L Porter (Non-Executive Director)	10-15	0	0	0	0	10-15
J Thornton (Non-Executive Director)	10-15	300	0	0	0	15-20
R Tyler (Chief Executive)	140-145	0	0	0	162.5-165	305-310
S Butt (Interim Director of Finance)	130-135	0	0	0	0	120-125
J Thomas (Interim Director of Nursing)	15-20	0	0	0	0	15-20
D Tkaczyk (Interim Director of Finance)	115-120	0	0	0	0	85-90

	2013/14					
Name and title	**Salary** (bands of £5,000) £000	**Benefits in kind** Rounded to the nearest £100	**Annual performance-related bonus** (bands of £5,000) £000	**Long-term performance-related bonus** (bands of £5,000) £000	**Pension-related benefits** (bands of £2,500) £000	**Total remuneration** (bands of £5,000) £000
J Beech (Non-Executive Director)	10-15	2,200	0	0	0	15-20
V Colwell (Non-Executive Director)	5-10	600	0	0	0	5-10
S Fenlon (Medical Director)	145-150	0	0	0	70-72.5	215-220
P Griffiths (Chairman)	40-45	4,200	0	0	0	45-50
R Hathaway (Director of Finance)	105-110	0	0	0	30-32.5	135-140
N Hayward (Non-Ececutive Director)	0-5	0	0	0	0	0-5
R Leach (Non-Executive Director)	0-5	0	0	0	0	0-5
A Parker (Director of Nursing and Quality)	95-100	200	0	0	27.5-30	125-130
L Porter (Non-Executive Director)	10-15	0	0	0	0	10-15
J Thornton (Non-Executive Director)	5-10	0	0	0	0	5-10
R Tyler (Chief Executive)	105-110	100	0	0	0-2.5	110-115
S Winning (Non-Exectutive Director)	10-15	0	0	0	0	10-15

No performance related bonus was paid in 2014/15 or 2013/14.

J Beech left the trust 31 March 2014.
S Winning left the trust 31 March 2014.
R Hathaway left the trust 8 December 2014.
S Butt joined the trust 1 May 2014 and left the trust 12 December 2014.
D Tkaczyk joined the trust 15 December 2014.
J Thomas joined the trust 2 February 2015.
P Griffiths left the trust 31 March 2015.
B Hobson joined the trust 1 July 2014.

Salary and pension entitlements of senior managers						
B) Pension benefits						
Name and title	**Real increase in pension at age 60**	**Lump sum at age 60 related to real increase in pension**	**Total accrued pension at age 60 at 31 March 2015**	**Lump sum at age 60 related to accrued pension at 31 March 2015**	**Cash equivalent transfer value at 31 March 2015**	**Cash equivalent transfer value at 31 March 2014**
	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	£000	£000
S Fenlon (Medical Director)	2.5-5	10-12.5	45-50	140-145	837	747
R Hathaway (Director of Finance)	0-2.5	0-2.5	30-35	95-100	553	532
A Parker (Director of Nursing and Quality)	0-2.5	0-2.5	30-35	90-95	600	582
R Tyler (Chief Executive)	7.5-10	22.5-25	35-40	105-110	652	489

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.

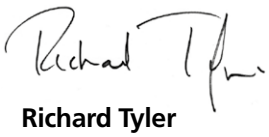
The CETV figures include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the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

The median remuneration of all the trust's staff is £27,718.

The ratio of the mid-point of the banded remuneration of the highest paid director to the median is 6.4 to 1.

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

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



Richard Tyler
Chief Executive and Accounting Officer
28 May 2015

5

NHS foundation trust code of governance

5.1 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.

5.2 Disclosures

	Part of schedule A	Relating to	Code of Governance reference	Summary of requirement
1.	2: Disclose	Board and council of governors	A.1.1	The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.
The trust's annual plan for 2013/14 as submitted to Monitor, the sector regulator for health services in England, describes how any disagreements between the council of governors and the board of directors will be resolved and still stands. The trust's schedule of matters was identified for review as part of a board governance assurance framework review undertaken in 2014/15 and deliberately deferred pending completion of the ongoing board governance review and embedding of changes made to the council of governors' governance systems in 2014/15. Until then the trust's constitution and standing orders provide the framework for decision making and delegation between the board of directors, council of governors and executive management team.				
2.	2: Disclose	Board, nomination committee, audit committee, remuneration committee	A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.
A register of this information is at appendix 12.1.				
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 12.2.				
4.	Additional requirement of FT ARM	Council of governors	n/a	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.
A register of this information is at appendices 12.1 and 12.2.				
5.	2: Disclose	Board	B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.
This information is included at appendices 12.1 and 12.3.				
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 12.3. 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. See also row 53 below.				
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 12.1. Paragraph 35 of the trust's constitution sets out the criteria and process for termination of a non-executive director contract.				

	Part of schedule A	Relating to	Code of Governance reference	Summary of requirement
8.	2: Disclose	Nomination committee	B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.
See section 4.3.1 above.				
9.	Additional requirement of FT ARM	Nomination committee	n/a	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.
Not applicable.				
10.	2: Disclose	Chair, council of governors	B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.
A register of directors' interests is kept by the trust and is available on request from the company secretary.				
11.	2: Disclose	Council of governors	B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.
The board governance assurance framework review undertaken in 2014/15 identified these duties and systems for review. They have, in part, been addressed by the development of the trust's statutory duties of co-operation (as agreed by the board of directors at its meeting held on 28 August 2014) and stakeholder engagement plan (as agreed by the board at its meeting held on 25 September 2014). Papers for the meetings and minutes of the discussions are published online on the trust's website at: http://qvh.nhs.uk/about_us/board_of_directors/meetings_in_public.php.				
12.	Additional requirement of FT ARM	Council of governors	n/a	If, during the financial year, the governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012.
Not applicable.				
13.	2: Disclose	Board	B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.
In 2014 the trust established a working group of the board of directors to examine the trust's board-level governance structure and processes. The project is ongoing and takes account of the Monitor *Well-Led Framework for Governance Reviews* and best practice from across the foundation trust sector and beyond. The review is internal but the trust intends to commission an independent review of governance in 2017 after its own internal review is complete and the recommendations are fully implemented and given time to embed. More information and progress reports can be found in papers of the meetings of the board of directors available from the trust's website at: http://qvh.nhs.uk/about_us/board_of_directors/meetings_in_public.php. The performance of the executive directors is assessed by the chief executive taking into account feedback sought from relevant members of staff and the board. The performance of the non-executive directors is assessed by the chair taking into account feedback sought from the executive directors and governors. The performance of the chair is assessed by the chair of the council of governors' appointments committee in collaboration with the senior independent director 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.				

	Part of schedule A	Relating to	Code of Governance reference	Summary of requirement
15.	2: Disclose	Board	C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). See also ARM paragraph 7.98.
See sections 3.2 and 3.5 above and section 10 below.				
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 section 10.8 below.				
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 2014/15 the trust's internal audit function was provided by Chantrey Vellacott. The scope of internal audit coverage included core financial systems testing and a review of stock management arrangements. The scope extended beyond financial systems and controls and for 2014/15 included a review of e-rostering and establishment controls, a review of 18 week breaches and an annual review of information governance standards.				
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 2014/15.				

	Part of schedule A	Relating to	Code of Governance reference	Summary of requirement
19.	2: Disclose	Audit committee	C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.
The audit committee meets quarterly to maintain an effective system of governance, risk management and internal control (including financial, clinical, operational and compliance controls and risk management systems). The committee is also responsible for maintaining an appropriate relationship with the trust's auditors. Audit committee meetings are attended by the trust's director of finance and other representatives of the trust's risk management functions, the external and internal auditors and local counter fraud service. At the beginning of every audit committee meeting, there is a closed session between the chair of the audit committee and committee members with the internal and external auditors. During 2014/15: • The committee received reports from the trust's internal and external auditors that provided the committee with a review of the trust's internal control and risk management systems. The committee considered the key financial estimates when reviewing the financial statements. • The committee reviewed its effectiveness and made changes to its terms of reference and work programme. It worked with the quality and risk committee to monitor the development and integration of the whistle-blowing policy following the conclusion of major national inquiries. • The internal auditors, Chantrey Vellacott were able to report full or significant assurance for 90% of the areas reviewed, resulting in a head of internal audit opinion of "significant assurance". See also row 17 above. • The council of governors agreed to extend the contract with KPMG for external audit services by a further 12 months from September 2014. It based its decision on an assessment of the work of the external auditors presented to the council by the chair of the audit committee at the council's meeting held in public on 19 June 2015. • The external auditors did not provide non-audit services. The trust has considered NHS income recognition as significant audit risks in terms of their impact on our financial statements. The main source of income for the trust is the provision of healthcare services to the public under contracts with NHS commissioners. Given the materiality in value and the judgement used in relation to areas such as accruals for services not yet invoiced and partially completed spells this has been identified as a risk in 2014/15. The trust participates in the national agreement of balances exercise. The agreement of balances exercise identifies mismatches between receivable and payable balances recognised by the trust and its commissioners and all differences are investigated by the finance team.			
20.	2: Disclose	Board, remuneration committee	D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.
Not applicable.				

	Part of schedule A	Relating to	Code of Governance reference	Summary of requirement
21.	2: Disclose	Board	E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.
The board of directors uses a variety of methods to understand the views of governors: • A governor representative attends all meetings of the board of directors in full (including seminars, workshops and meeting sessions held in private) and is an active participant. The governor representative is expected to provide feedback to governor colleagues to contribute to the council's statutory duty to hold non-executive directors to account for the performance of the board of directors. • Directors attend all meetings of the council of governors held in public. In 2014/15 council meeting agendas were improved to provide more opportunities for non-executive directors to report to the council and for dialogue between non-executive directors and governors generally. • The board invites a governor representative to attend meetings of its sub-committees to participate and feedback to governor colleagues. As the sub-committees are chaired by non-executive directors this facility gives more governors the opportunity to observe non-executive directors performing their duties as well as providing governors with wider insight into the operational activities of the trust and their corporate governance. In line with legislation introduced under the Health and Social Care Act 2012, prior to each meeting a copy of the board of directors' meeting agenda is forwarded to the council of governors. Governors are invited to forward any comments on the agenda and general feedback from governors and members to their governor representative for representation at board meetings. All directors attend the annual members meeting and any other members meeting including those held to support members standing for election as a governor.				
22.	2: Disclose	Board, membership	E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.
The trust's membership strategy was reviewed by the trust and presented to governors and non-executive directors at the trust's annual membership meeting on 11 September 2014. The strategy aimed to maintain a steady public membership at roughly 8,900 members and to increase the proportion of the membership base for which the trust holds an email address in order to facilitate more regular and timely communication with members. Significant efforts were made to achieve this with the help and goodwill of a small group of governors. A change in legislation in 2014 allowed new model election rules to apply to NHS foundation trust constitutions and establish online voting for governor elections. The trust's council of governors approved the adoption of the new model election rules at its meeting on 11 December 2014 with a view to holding online voting for its next elections. The trust recognises the challenge and limitations of establishing a representative membership base as the trust serves a large regional population with a range of specialist services and a smaller local population with a range of community services.				
23.	2: Disclose	Membership	E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.
Members who wish to communicate with the directors should contact the company secretary on 01342 414362 or info@qvh.nhs.uk. Members who wish to communicate with governors should contact the deputy company secretary on 01342 414200 or hilary.saunders@qvh.nhs.uk. This information is also available from the trust's website at: http://qvh.nhs.uk/about_us/board_of_directors/index.php and http://qvh.nhs.uk/for_members/board_of_governors.php				
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 2015, the number of members within the public constituency was 8,416, and the staff constituency was 978. The trust's membership strategy was reviewed by the trust and presented to governors and non-executive directors at the trust's annual membership meeting on 11 September 2014. It is available online at http://qvh.nhs.uk/for_members/public_meetings.php. See row 22 above for further information.				

	Part of schedule A	Relating to	Code of Governance reference	Summary of requirement
25.	Additional requirement of FT ARM (based on FReM requirement)	Board, council of governors	n/a	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report. See also ARM paragraph 7.33 as directors' report requirement.
A register of directors' and governors' interests is kept by the trust and is available on request from the company secretary.				
26.	6: Comply or explain	Board	A.1.4	The board should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust's effectiveness, efficiency and economy as well as the quality of its health care delivery.
Compliant.				
27.	6: Comply or explain	Board	A.1.5	The board should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance.
Compliant.				
28.	6: Comply or explain	Board	A.1.6	The board should report on its approach to clinical governance.
The trust's clinical governance group is responsible for: • Ensuring that QVH meets its statutory duty of quality through clinical governance. • Ensuring the best use of available resources for patients by establishing policies for effective clinical services. • Identifying and instigating policy improvement from clinical audit and outcomes monitoring processes. • Identifying and mitigating risks relating to the development and implementation of clinical policy. The group meets monthly and reports to the quality and risk sub-committee of the board which, in turn, provides assurance to the full board of directors. The group is chaired by the medical director and its members include the director of nursing, medical directors of clinical specialties, matrons and service managers. See also the 'review of quality of care' section of the quality report below and further commentary throughout the report.				
29.	6: Comply or explain	Board	A.1.7	The chief executive as the accounting officer should follow the procedure set out by Monitor for advising the board and the council and for recording and submitting objections to decisions.
Compliant				
30.	6: Comply or explain	Board	A.1.8	The board should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life.
The trust's standards of business conduct and behaviour policy was revised and approved by the nomination and remuneration committee in February 2014 and will be reviewed in 2016.				
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 reflects high standards of probity and responsibility.
See row 30 above.				
32.	6: Comply or explain	Board	A.1.10	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors.
Compliant.				
33.	6: Comply or explain	Chair	A.3.1	The chairperson should, on appointment by the council, meet the independence criteria set out in B.1.1. A chief executive should not go on to be the chairperson of the same NHS foundation trust.
In 2014, a search was directed on behalf of governors by the appointments committee which used the services of executive search agency Odgers Berndtson. The Odgers team worked with the appointments committee to develop and agree the candidate brief, taking into account the views of the board of directors on the qualities, skills and experience required. This brief also took into account independence criteria as set out in B.1.1 of the Code of Governance. At an extraordinary general meeting of the council of governors on 26 June 2014 the council of governors appointed a non-executive director, Beryl Hobson, to succeed Peter Griffiths as trust chair on 1 April 2015. Beryl Hobson has not been chief executive of the trust and met the independence criteria on appointment. See also row 10 above and row 48 below.				

	Part of schedule A	Relating to	Code of Governance reference	Summary of requirement
34.	6: Comply or explain	Board	A.4.1	In consultation with the council, the board should appoint one of the independent non-executive directors to be the senior independent director.
Lester Porter was appointed as the trust's senior independent director in April 2014 when the previous senior independent director Jeremy Beech came to the end of his term as non-executive director. As required by the trust's constitution, this decision was made in consultation with the council of governors.				
35.	6: Comply or explain	Board	A.4.2	The chairperson should hold meetings with the non-executive directors without the executives present.
The chair has held exclusive monthly meetings with the non-executive directors throughout the course of 2014/15.				
36.	6: Comply or explain	Board	A.1.6	The board should report on its approach to clinical governance.
The trust's standing orders stipulate the following: • Minutes of the proceedings of a board meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it. • No discussion shall take place upon the minutes except upon their accuracy or where the chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting. • Minutes shall be circulated in accordance with board members' wishes. Where providing a record of a public meeting the minutes shall be made available to the public as required by the Code of Practice on Openness.				
37.	6: Comply or explain	Council of governors	A.5.1	The council of governors should meet sufficiently regularly to discharge its duties.
The trust's constitution stipulates that the council of governors should meet at least four times per year. During 2014/15 the cycle of meetings of the council of governors was adjusted to better facilitate its work programme and responsibility to hold the non-executive directors to account for the performance of the board of directors. As a result, the council met three times during the financial year on 19 June 2014, 11 September 2014 and 11 December 2014. It met again shortly after the financial year ended on 9 April 2015 and will meet on another three occasions during 2015/16.				
38.	6: Comply or explain	Council of governors	A.5.2	The council of governors should not be so large as to be unwieldy.
The council of governors comprises 20 public members, three staff members and three stakeholder representatives, as established by paragraph 14 of the trust's constitution.				
39.	6: Comply or explain	Council of governors	A.5.4	The roles and responsibilities of the council of governors should be set out in a written document.
The sector regulator for health services in England – Monitor – publishes guides to the duties and legal obligations of foundation trust governors for governors. General duties of the trust's council of governors are included in provision 19 of the trust's constitution.				
40.	6: Comply or explain	Council of governors	A.5.5	The chairperson is responsible for leadership of both the board and the council but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive to their meetings and inviting attendance by other executives and non-executives, as appropriate.
Provision 20 of the trust's constitution explains the arrangements in place for the trust.				
41.	6: Comply or explain	Council of governors	A.5.6	The council should establish a policy for engagement with the board of directors for those circumstances when they have concerns.
Provision 52 of the trust's constitution sets out provisions for disputes between the council of governors and board of directors.				
42.	6: Comply or explain	Council of governors	A.5.7	The council should ensure its interaction and relationship with the board of directors is appropriate and effective.
The council of governors relies on several roles and functions to ensure its interaction and relationship with the board of directors is appropriate and effective. These include: the role of the trust chair as chairperson of both bodies; the role of the company secretary as advisor to both bodies; the role of the governor representative to the board of directors; and the work of the governor steering group.				
43.	6: Comply or explain	Council of governors	A.5.8	The council should only exercise its power to remove the chairperson or any non-executive directors after exhausting all means of engagement with the board.
Not applicable in 2014/15. Paragraph 35 of the trust's constitution describes the process for removal of the chair and other non-executive directors.				
44.	6: Comply or explain	Council of governors	A.5.9	The council should receive and consider other appropriate information required to enable it to discharge its duties.
Compliant.				

	Part of schedule A	Relating to	Code of Governance reference	Summary of requirement
45.	6: Comply or explain	Board	B.1.2	At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent
Compliant. The board of directors comprises a chair, four other non-executive directors, a chief executive and three executive directors.				
46.	6: Comply or explain	Board, council of governors	B.1.3	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust.
Compliant. See provision 18 of the trust's constitution.				
47.	6: Comply or explain	Nomination committee	B.2.1	The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors.
Compliant.				
48.	6: Comply or explain	Board, council of governors	B.2.2	Directors on the board of directors and governors on the council should meet the 'fit and proper' person test described in the provider licence.
At its meeting on 18 December 2014, the board noted The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which came into force on 27 November 2014. All members of the board have made a declaration that they: • are of 'of good character'; • have the qualifications, skills and experience necessary to hold the position on the board; • are capable by reason of health, after reasonable adjustments are made, to carry out the tasks required of a person holding that board role; • have not been responsible for, or privy to, or contributed to, or facilitated, any misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider; and • are not prohibited from holding the relevant office by or under any enactment. Since the regulations were published the Care Quality Commission has clarified that the regulations do not apply to governors except where a governor has a place on the board.				
49.	6: Comply or explain	Nomination committee	B.2.3	The nominations committee(s) should regularly review the structure, size and composition of the board and make recommendations for changes where appropriate.
Compliant.				
50.	6: Comply or explain	Nomination committee	B.2.4	The chairperson or an independent non-executive director should chair the nominations committee(s).
Compliant. See appendix 12.1.				
51.	6: Comply or explain	Nomination committee, council of governors	B.2.5	The governors should agree with the nominations committee a clear process for the nomination of a new chairperson and non-executive directors.
The appointments committee is a sub-committee of the trust's council of governors. Part of its remit is to oversee the appointment processes for the chair and non-executive directors, making recommendations in this regard to the council of governors. The committee's terms of reference are published online on the trust's website at: http://qvh.nhs.uk/for_members/board_of_governors.php In 2014/15, a search for a chair designate was directed on behalf of governors by the appointments committee using the services of executive search agency Odgers Berndtson. In anticipation of the chair designate assuming the role of chair, governors also initiated a search for another non-executive director to join the board of directors in April 2015 to maintain a non-executive majority. This search was also supported by Odgers Berndtson. For both appointments, the process described below was adopted: • The Odgers team worked with the appointments committee to develop and agree the candidate brief. • Odgers searched for candidates across the NHS and a wide range of associated and other industries including private healthcare and life-science industries. It provided the appointments committee with regular progress reports, detailing the candidates identified and, over time, how each of them had progressed in relation to the search. Odgers provided advice on candidate suitability as well as feedback from candidates regarding their personal and professional circumstances and motivations. A number of candidates who featured in the search were not kept in the processes, usually because they did not meet the person specification closely enough. • The selection process consisted of long-listing and then shortlisting candidates by the appointments committee prior to final interviews. The panel for the final interviews comprised a majority of governors. • The panel recommended candidates to the appointments committee who: › could offer the best possible fit to the person criteria for the role from the search and selection process undertaken › to the best of its knowledge were 'fit and proper persons' to be appointed to the roles › were supported by appropriate references. • The panel advised the appointments committee to propose to the council of governors that the panel's recommended candidate should be appointed to the role. • Governors were advised that approval means that a council is assured that, in making an appointment, its appointments committee has complied with the law and relevant guidance, followed a robust process and found a candidate who fulfils the specification for the role.				

	Part of schedule A	Relating to	Code of Governance reference	Summary of requirement
52.	6: Comply or explain	Nomination committee	B.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist of a majority of governors.
Compliant. Terms of reference for the appointments committee are published on the trust's website at http://qvh.nhs.uk/for_members/board_of_governors.php				
53.	6: Comply or explain	Council of governors	B.2.7	When considering the appointment of non-executive directors, the council should take into account the views of the board and the nominations committee on the qualifications, skills and experience required for each position.
The appointments committee's terms of reference state that before any appointment is made by the council of governors, it should evaluate the balance of skills, knowledge and experience of the non-executive directors and, in light of this evaluation, prepare a description of the role and capabilities required for a particular appointment. In 2014 a skills audit of existing non-executive directors was undertaken by the chair designate to map skills to the trust's key strategic objectives and identify gaps. The results of the audit were used to develop and agree the candidate brief for the recruitment of a new non-executive director in 2014/15.				
54.	6: Comply or explain	Council of governors	B.2.8	The annual report should describe the process followed by the council in relation to appointments of the chairperson and non-executive directors.
See row 51 above.				
55.	6: Comply or explain	Nomination committee	B.2.9	An independent external adviser should not be a member of or have a vote on the nominations committee(s).
Compliant.				
56.	6: Comply or explain	Board	B.3.3	The board should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity.
Not applicable.				
57.	6: Comply or explain	Board, council of governors	B.5.1	The board and the council governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make.
Compliant. Papers for meetings of the board of directors and council of governors are available from the trust's website. In addition to meeting papers, the board of directors and council of governors receive regular briefings from the trust, its regulators and its representative bodies to inform and provide context to the functions and decisions of the board and the council. Throughout much of 2014/15 the trust's board of directors received supplementary weekly updates by email from the interim director of operations on the status of performance against 18 week referral to treatment targets. In December 2014 a new tool was provided for governors to log general queries to non-executive directors and the trust's 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 independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors.
Compliant.				
60.	6: Comply or explain	Board, committees	B.5.4	Committees should be provided with sufficient resources to undertake their duties.
Compliant.				
61.	6: Comply or explain	Chair	B.6.3	The senior independent director should lead the performance evaluation of the chairperson.
The performance of the chair is assessed by the chair of the council of governors' appointments committee in collaboration with the senior independent director taking into account feedback sought from directors and governors.				

	Part of schedule A	Relating to	Code of Governance reference	Summary of requirement
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.				
63.	6: Comply or explain	Chair, council of governors	B.6.5	Led by the chairperson, the council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities.
The collective performance of the council was assessed thoroughly in 2014/15. Communication with members and the public on how the council has discharged its responsibilities is provided in two annual newsletters and regular email communication with members who have provided the trust with their email address.				
64.	6: Comply or explain	Council of governors	B.6.6	There should be a clear policy and a fair process, agreed and adopted by the council, for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council or has an actual or potential conflict of interest which prevents the proper exercise of their duties.
The circumstances in which a governor may be disqualified or removed from the council of governors are set out in provision 18 of the trust's constitution.				
65.	6: Comply or explain	Board, remuneration committee	B.8.1	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.
In April 2014 the nomination and remuneration committee agreed for the director of finance to leave the trust to undertake a secondment with the local NHS England area team by mutual agreement. During the secondment, the post holder remained an employee of the trust and was entitled to payment in lieu of notice at the end of the secondment period, in accordance with the contract of employment. This allowed the individual to step down as director of finance and enabled the trust to appoint to the role, initially on an interim basis. Consequently the trust minimised its exposure to potential risk and kept its regulator apprised of the circumstances and considerations throughout.				
66.	6: Comply or explain	Board	C.1.2	The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary. See also ARM paragraph 7.17.
See section 2.4 above.				
67.	6: Comply or explain	Board	C.1.3	At least annually and in a timely manner, the board should set out clearly its financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcomes data, to allow members and governors to evaluate its performance.
Compliant. The trust publishes a summary annual plan on its website each year. Information on the trust's business and operations are published on the trust's website each month in the form of papers for the meetings of the board of directors. The trust publishes its annual report and quality and financial accounts each year and clinical outcomes data is published on the trust's website for each clinical specialty at appropriate intervals.				

	Part of schedule A	Relating to	Code of Governance reference	Summary of requirement
68.	6: Comply or explain	Board	C.1.3	a) The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS foundation trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS foundation trust. b) The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in: • the NHS foundation trust's financial condition; • the performance of its business; and/or • the NHS foundation trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS foundation trust.
Compliant.				
69.	6: Comply or explain	Board, audit committee	C.3.1	The board should establish an audit committee composed of at least three members who are all independent non-executive directors.
The QVH audit committee comprises two independent non-executive directors. The board considers it to be appropriately commensurate with the size and turnover of the trust.				
70.	6: Comply or explain	Council of governors, audit committee	C.3.3	The council should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors.
The trust's standing orders state that by virtue of the National Health Service Act 2006, (as amended by the Health and Social Care Act 2012), the powers and duties of the council of governors include the appointment and, if appropriate, the removal of the trust's auditor. At its meeting in June 2014 the council of governors approved the recommendation to reappoint KPMG as external auditors for one further year.				
71.	6: Comply or explain	Council of governors, audit committee	C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust.
The trust's external auditor was appointed in August 2011.				
72.	6: Comply or explain	Council of governors	C.3.7	When the council ends an external auditor's appointment in disputed circumstances, the chairperson should write to Monitor informing it of the reasons behind the decision.
Not applicable.				
73.	6: Comply or explain	Audit committee	C.3.8	The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.
In 2014/15, Chantrey Vellacott 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. Whistle-blowing is the responsibility of the quality and risk committee. However, the audit committee is responsible for providing assurance that the whistle-blowing process is fit for purpose and working effectively as required by the board.				
74.	6: Comply or explain	Remuneration committee	D.1.1	Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels.
Compliant.				
75.	6: Comply or explain	Remuneration committee	D.1.2	Levels of remuneration for the chairperson and other non-executive directors should reflect the time commitment and responsibilities of their roles.
Compliant.				

	Part of schedule A	Relating to	Code of Governance reference	Summary of requirement
76.	6: Comply or explain	Remuneration committee	D.1.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination.
Not applicable.				
77.	6: Comply or explain	Remuneration committee	D.2.2	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments.
Compliant.				
78.	6: Comply or explain	Council of governors, remuneration committee	D.2.3	The council should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.
Not applicable in 2014/15.				
79.	6: Comply or explain	Board	E.1.2	The board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums.
See row 11 above.				
80.	6: Comply or explain	Board	E.1.3	The chairperson should ensure that the views of governors and members are communicated to the board as a whole.
Responsibility for ensuring that the views of governors and members are communicated to the board as a whole is shared between the chair, the company secretary and the governor representative to the board of directors.				
81.	6: Comply or explain	Board	E.2.1	The board should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate.
At its meeting held on 25 September 2014 the board of directors agreed the trust's stakeholder engagement plan. The relevant papers from and minutes from the meeting are published online on the trust's website at: http://qvh.nhs.uk/about_us/board_of_directors/meetings_in_public.php				
82.	6: Comply or explain	Board	E.2.2	The board should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each.
See row 81 above. The stakeholder engagement plan allocates a senior lead on behalf of the trust to each stakeholder.				

6

Quality reports

Part 1: Statement on quality

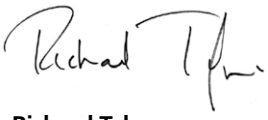
Chief executive's statement

At Queen Victoria Hospital NHS Foundation Trust (QVH) we pride ourselves on the quality of care that we provide for our patients.

We are very pleased with the recently published national NHS inpatient survey results where our patients have recognised our sustained commitment to quality of care and patient experience and rated us amongst the best in England, achieving the highest scores in England for ten of the questions. Similarly, results from the NHS friends and family test indicate that over 99% of our patients would recommend us.

While we have performed well, we believe in continuous improvement. These quality accounts summarise our performance across a range of issues in 2014/15 and set out our key priorities for 2015/16 which we believe will further improve our patients' care and hospital experience.

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



Richard Tyler
Chief Executive

Part 2: Priorities for improvement and statements of assurance from the board

Performance against 2014/15 priorities

Priorities for 2014/15 were influenced by information from national and local reports and audit findings along with the views of the trust's governors, the programme board (which includes representation from NHS Crawley CCG and Horsham and Mid Sussex CCG), patient feedback and staff suggestions from across the organisation.

Four priorities were identified for 2014/15, covering patients' experience, the effectiveness of their medical care, and patient safety. In addition, we identified two priorities from 2013/14 that we thought would benefit from continued focus to embed them into the routine work of the trust. Whilst not formal 2014/15 quality account priorities, we have continued to monitor progress in these two areas during 2014/15:

- Improve outpatient experience for our patients
- Patient consent for elective surgery prior to day of surgery.

Priority 1

Provision of clinical outcome measures

Our aim

For 2014/15 our plan was to publish outcome measures at consultant or team level as appropriate. They were to be made up of both patient reported outcome measures (PROMs) and clinical outcome measures as decided in consultation with clinicians and patient focus groups. A total of six outcome measures were planned for publication during the year on the trust website.

Our rationale

At QVH we aim to continually improve the care we provide and share information about our performance with the public and our patients. Quality assurance demands that we critically examine and openly publish the effectiveness of procedures from the perspective of both patient and doctor. This enables us to continually improve the service we provide and ensure that no matter who delivers the care, patients and commissioners of services can be assured that all patients receive demonstrably high quality care.

We achieved

We developed and populated a monthly spreadsheet with consultant-level safety metrics for use with clinicians to understand and improve outcomes, contribute to revalidation and for board assurance.

In the first nine months we published outcome measures for QVH consultants in four areas:

- orthognathic surgery
- orthodontics
- head and neck surgery
- sleep.

The original aim was to publish outcomes in six areas. Four other services made good progress with this initiative during the year:

- Breast reconstruction developed a local database which incorporated clinical details and patient feedback. Unfortunately this database could not be linked to existing trust IT systems for patient demographics. Introduction of a new PROM registry by the British Association of Plastic Reconstructive and Aesthetic Surgeons has negated the further development of this local database.
- Anaesthetics developed a local database which incorporated clinical details. As with the breast database, there were similar IT challenges which were recognised early on in the project. Additional resources were acquired which enabled more comprehensive data collection. The collection of this data is now embedded and outcomes data will be available during 2015/16.

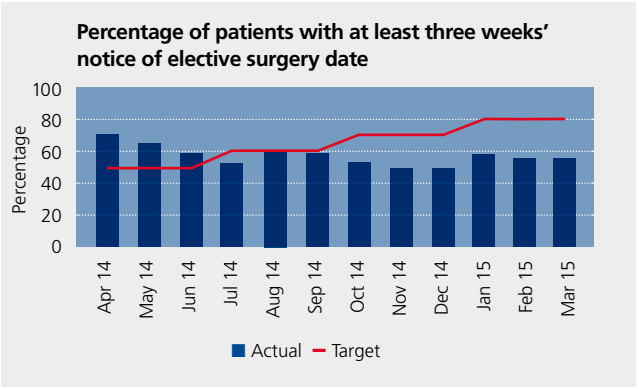
- Burns data proved very challenging to collate by consultant due to the multidisciplinary nature of the care, with multiple surgeons involved, and the length of treatment. Interrogation of the IBID database designed for commissioning purposes continues as this contains clinical outcomes. This will remain as part of our routine quality account review by service and key measures have been identified from this to be used to facilitate national comparison.
- Eye service consultants have joined a national website, www.iwantgreatcare.org which enables patients to provide feedback about individual doctors. Whilst this provides PROM measurement by consultant, not every patient chooses to provide feedback so it has not been counted as a fourth published outcome measure. However, this feedback option is available for all doctors and the eye consultants are actively encouraging other consultants to promote and use this service and the trust has added this link to its website.

Priority 2
Scheduling of elective surgery

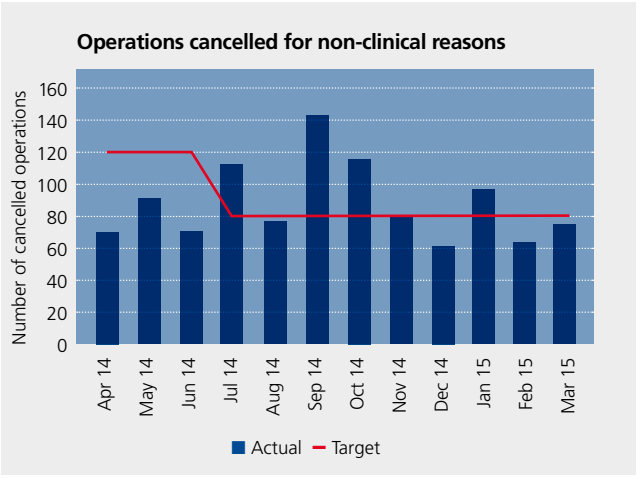
Our aim
For 2014/15, we planned to offer 80% of elective surgical patients dates with at least three weeks' notice by the end of March 2015. This excluded cancer patients and patients requiring donor tissue as these cases are planned to meet individual patient need.

Our rationale
At QVH, we understand that having advance notice of proposed surgery dates is important to patients as it allows them to plan their personal commitments accordingly. The national guidance on managing waiting lists states that all patients having planned surgery should ideally be offered a date for surgery that provides at least three weeks' notice. This does not apply to cancer patients for whom organisations are required to meet shorter timescales. Delivery of this priority will enhance our patients' experience. Improvements in achieving this priority also contribute to our 2014/15 Commissioning for Quality and Innovation (CQUIN) measure on reducing the number of surgery dates given to patients that are subsequently changed.

We achieved
Despite completing a number of actions to improve three week notice elective surgery, we have not achieved the 80% target we were aiming for. The operational focus of the trust has been to reduce the overall backlog of patients waiting for surgery in line with the national drive to improve waiting times. We will continue to work on this priority as part of our 2015/16 quality priorties.



The number of operations cancelled due to non-clinical reasons has steadily reduced to the expected target, except for a small peak in January where an increase in trauma admisisons and staff sickness resulted in slightly higher cancellations for the month. We are continuing to review processes and will be continuing to ensure non-clinical reasons for cancellation are minimised.



Priority 3

Increase the number of elective patients receiving treatment on the day of their outpatient appointments for minor skin lesions ('see and do' clinics)

Our aim
For 2014/15 we planned to increase the number of elective patients seen and treated on the same day by at least 50%.

Our rationale
Many patients visit QVH for their outpatient appointment and then have to return for minor surgery at a later date. Increasing the number of patients that are seen and treated for minor surgical interventions on the same day as their outpatient appointment would improve their experience as it reduces the number of visits they are required to make to hospital and shortens the length of their overall care. In addition to the direct benefits for patients, changing our ways of working to see more patients on the same day will reduce the administrative time and resource previously required to book patients for multiple visits and to produce clinic letters. This means that staff will be able to focus more time on managing patients with more complex needs through their care pathway.

We achieved
We aimed to increase by 50% the number of patients seen and treated on the same day in 2014/15 and exceeded this target. In 2015/16, with the introduction of a new day treatment centre, we are planning to further increase the numbers seen and treated on the same day.

	2013/14	2015/15	Increase
Cases seen and treated on the same day	240	453	88.75%

Priority 4

Introduction of an electronic system to evidence that safe staffing levels are provided on wards

Our aim
We planned to introduce an additional safe care module to our electronic roster system to make our staffing levels more visible by the end of June 2014. We also planned to provide real-time data for staffing levels across wards in relation to patient numbers and acuity to compliment professional judgement and enable more robust redeployment or enhancement of staffing levels in real-time and support the delivery of safe care to patients.

Our rationale
The report by Sir Robert Francis on the care provided at Mid Staffordshire recommended that organisations should review the staffing they provide to deliver care at ward level. This was further supported by the document *How to ensure the right people, with the right skills, are in the right place at the right time* published by the National Quality Board. The document set out requirements for NHS organisations to have robust systems in place to ensure sufficient staffing capacity and capability to provide safe care in all areas at all times.

We achieved
The safe care module has been implemented in ward areas, albeit slightly later than planned. The pilot commenced in January 2015 with all wards going live in February and March. Ward leads and senior nursing staff review the data at least twice a day and use this information to facilitate safe staffing. It has been a valuable tool for highlighting areas where staffing levels are good and ward teams understand the rationale when they are asked to relinquish staff to support other areas. Work will continue on this project to realise other benefits of the system, such as sickness reporting.

Priorities for 2015/16

Priorities for 2015/16 have been influenced by our progress against our 2014/15 priorities, the trust's governors, our lead clinical commissioning group and staff from across the organisation through their contributions to *QVH 2020*, our long-term strategic plan.

In addition, information was considered from national reports, our results from national inpatient and cancer surveys, in-house patient experience reviews, NHS friends and family test feedback, clinical incident reporting, complaints, patient safety reviews and clinical audit.

Three priorities have been identified, covering patients' experience, patient safety and operational excellence. Having monitored and reviewed last year's priorities, we have decided that we will also retain the scheduling of elective surgery as a priority again for the coming year.

The three priorities proposed for QVH for 2015/16 are:

- Scheduling of elective surgery
- Expand trauma capacity to reduce waits for trauma surgery
- Improving patient experience of QVH food.

Priority 1
Scheduling of elective surgery

At QVH, we understand that having advance notice of proposed surgery dates is important to patients as it allows them to plan their personal commitments accordingly. The national guidance on managing waiting lists states that all patients having planned surgery should ideally be offered a date for surgery that provides at least three weeks' notice. This does not apply to cancer patients for whom organisations are required to meet shorter timescales or patients with complex needs who, for example, may require donor tissue. Delivery of this priority will enhance our patients' experience.

By the end of 2014/15, we aimed to be scheduling 80% of elective surgical patients with at least three weeks' notice of their planned operation date. A number of actions were taken during the year to achieve this. However, they did not have as much impact as we would have liked. Our objective for 2015/16 will therefore be to continue the work started last year with further targeted work with specific teams to improve our performance. Our aim is that the percentage of patients booked with at least three weeks' notice increases in a phased manner during Q2 and Q3 in order to reach and sustain 80% by the end of 2015/16.

Our current baseline (2014/15 months 1-10) is an average of 57.8%. Our target for 2015/16 will be a phased increase to 80% by Q4.

Monitoring and reporting will continue monthly and will be presented to the management team and included within the board papers. The metrics included will be the percentage of patients scheduled with three weeks' notice and the number of elective cases cancelled and rebooked for non-clinical reasons (i.e. for administrative reasons rather than at the request of the patient or for a clinical reason).

Priority 2
Expand trauma capacity to reduce waits for trauma surgery

We are proud to be providing a good patient experience across all our services, whilst continuing to look to see where further improvements can be made. The QVH trauma service has reached a maximum capacity and in some weeks has as many as four referrals that it is unable to accept. There have also been occasions where trauma surgery has led to elective operations being cancelled, some trauma cases have lengthy waits and some trauma surgery is conducted out of hours, none of which is in line with best practice.

Creating additional theatre capacity will improve trauma services by decreasing the associated risk of operating out of hours and improving the patient experience. This will also enable us to reduce waiting times following injury by offering one-stop treatment services and to provide increased access and support for lower leg trauma across the region.

For 2015/16, we plan to increase the available theatre capacity for trauma patients by June. This will ensure that QVH can provide a service that enables 90% of cases to be treated within 24 hours of admission and almost eradicate the need to operate on cases out of hours between 10pm – 1am. In addition to monitoring these two measures, we will also monitor overall patient waits for treatment, number of attendances and length of stay.

Our current baseline for the percentage of patients treated within 24 hours of admission is 88%. By Q3 we aim for 90% of all patients to be treated within 24 hours and aim to achieve 92% by the end of Q4. We also plan to reduce by 50% the number of patients operated on out of hours (after 10 pm).

Monitoring and reporting will continue monthly and will be presented to the management team and included within the board papers.

Priority 3
Improving patient experience of QVH food

Providing appetising, nutritious food to a wide range of patients at varying levels of recovery in hospital is a challenge. However, we must listen and learn from the feedback of our patients and strive to improve the way we produce, choose and serve meals to our patients. QVH scores for some of the questions about food in the 2014 national NHS inpatient survey were significantly worse than in the previous year. In our NHS friends and family test scores for food, a third of our patients rated their food as fair or poor in Q3.

For 2015/16, we plan to engage with patients during Q1 to find out what changes they would like made to the food we provide, paying particular attention to the views of patients with swallowing difficulties or burns. We will use this information to review menus and patient choice, aiming to reduce the number of fair and poor ratings for food in our friends and family test scores.

Our current baseline at Q3 of 2014/15 is for 'fair' or 'poor' ratings from 34% of patients (of these 11% rated as 'poor').We aim to have 'fair' or 'poor' ratings at 20% or less with 'poor' rating not greater than 5% by the end of Q4.

Progress on our achievements will be monitored by the patient experience group and reported quarterly in the patient experience report presented to the management team and included in the board report.

Statements of assurance from the trust board

Review of services

During 2014/15 QVH provided burns care, general plastic surgery, head and neck surgery, maxillofacial surgery, corneoplastic surgery and community and rehabilitation services. QVH has reviewed all the data available to it on the quality of care in all of these NHS services. The income generated by the relevant health services reviewed in 2014/15 represents 100% of the total income generated from the provision of relevant health services by QVH for 2014/15.

Review of quality of care

During 2014/15, a working group has been examining board governance structures with reference to Monitor's 2014 Well-Led Framework for governance reviews and the Francis Inquiry findings. An interim report has been presented to the board alongside a list of initial recommendations and a final report will be presented to the board in June 2015 with final recommendations being implemented by October 2015.

In 2014/15 we continued to provide the vast majority of our patients with excellent experiences of care; 99% of our in-patients would recommend QVH to friends and family. The 2014 national NHS inpatient survey showed that we were significantly better than average on 45 of the 62 questions asked, about the same on 16, worse than average on only one. We achieved the highest scores in England for ten of the questions which included themes on overall experience, emotional support, pain control, enough nurses on duty and cleanliness of the hospital. There are no quality concerns from Monitor or the CQC for 2014/15. Monitor rate QVH as green for quality and the CQC intelligent monitoring system rates us at 6 (which is the lowest risk) for priority inspection.

QVH has a governance structure in place which ensures that, through the responsible committees and speciality directorate reviews, the executive team are able to assure themselves regularly on the quality of services provided to patients. At these meetings, the safety of care is reviewed through reports on incidents, infection control and identified risks. Where there are concerns or further assurance is felt to be required, action plans are put in place and reviewed at monthly operational meetings of the directorates or meetings involving the senior managers. Clinical effectiveness is reviewed through reports on cancelled operations, clinical indicators, clinical outcome measures, waiting times for surgery and patient complaints. Patient experience is reviewed through complaints and feedback questionnaires and is further supported by the national patient surveys.

A summary quality dashboard is presented monthly to the clinical cabinet and board of directors and the audit committee routinely reviews the framework of control in respect of quality, reporting regularly to the board of directors.

Where a significant incident or concern occurs or is identified by either the executive team or a directorate an immediate investigation is undertaken. Actions are documented and regularly reviewed until completed. All serious incidents are reported through to the trust board and actions are followed up and monitored through the quality and risk committee.

All the executive directors at QVH have been involved in the drafting of the quality account and believe the contents to be a true and accurate reflection of the quality of care provided by QVH.

Participation in clinical audits

During 2014/15, four national clinical audits and three national confidential enquiries covered relevant health services that QVH provides.

During 2014/15, QVH fully participated in 50% of the specified national clinical audits and fully participated in 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to take part in.

The national clinical audits and national confidential enquiries that QVH was eligible to participate in during 2014/15 are as follows:

National clinical audits	Participation
Head and Neck Oncology (DAHNO)	✓
Rheumatoid and Early Inflammatory Arthritis	✓
National Cardiac Arrest Audit (NCAA)	✗
Case Mix Programme (CMP)	✗
National confidential enquiries	
Gastrointestinal Haemorrhage (NCEPOD)	✓
Sepsis (NCEPOD)	✓
Tracheostomy Care (NCEPOD)	✓

We do not participate in the National Cardiac Arrest Audit as our number of cardiac arrests treated with cardiopulmonary resuscitation is very low (usually less than five per year). All cardiac arrests are audited locally.

We do not participate in the Adult Critical Care Case Mix Programme because our intensive care unit serves a very select case mix, predominately burns patients and post-surgical head and neck cancer patients. This presents difficulties with comparison as the national audit is primarily focused on adult general critical care units.

The methodology of the National Confidential Enquiry into Maternal Deaths (CEMD) has recently changed to include any woman who dies during pregnancy or within a year of her pregnancy ending, whatever the cause of death (which now includes accidental or incidental causes). We responded to a request for historic data during 2014, but have not previously been required to participate in the study.

The national clinical audits and national confidential enquiries that QVH participated in, and for which data collection was completed during 2014/15, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the term of that audit or enquiry.

National audits / confidential enquiries	% cases submitted
Head and Neck Cancer (DAHNO)	100% relevant cases between November 2013 and October 2014
Gastrointestinal Haemorrhage (NCEPOD)	100% relevant cases and organisational data submitted
Sepsis (NCEPOD)	No relevant cases, but organisational data submitted
Tracheostomy Care (NCEPOD)	100% relevant cases and organisational data submitted

Other national audits we have participated in during 2014/15 include:

- National NHS Adult Inpatient Survey
- National Cancer Patient Experience Survey
- National NHS Children's Inpatient and Day Case Survey
- The International Burn Injury Database (IBID).

The reports of eleven national clinical audits were reviewed by the provider in 2014/15 and QVH intends to take the following actions to improve the quality of healthcare provided:

- Coordinate a response to a number of national patient and staff surveys via the trust's patient experience group and Macmillan team, and to monitor actions taken.
- Launch of tracheostomy study days to provide specialist training via a mix of lectures, workshops, scenarios and observed care as well as completion of national e-learning course.
- Convene a meeting of a lower limb strategy group to discuss the growth of orthoplastic services, within which the NCEPOD recommendations will form an integral part.
- Following implementation, continue the use of a single, flexible and robust database for collection of head and neck clinical outcomes data.
- Continue to ensure the presentation of findings of relevant national audits and confidential enquiries to a trust-wide audience to increase awareness.

The reports of 150 local clinical audits were reviewed by the provider in 2014/15 and QVH intends to take the following actions to improve the quality of healthcare provided:

- Progress an initial clinical audit looking at a new method of collecting patient reported outcomes in anaesthesia to a research proposal.
- Following an ongoing programme of clinical outcomes and clinical audit activity, publish a range of consultant-level clinical outcomes data on the trust's website.
- Implement a new checklist for post-surgical orbital care.
- Build on previous 'compliance in practice' activity by further developing the overall process, with a view to trust-wide roll-out.
- Continue development and improvement in the design and audit processes of the WHO surgical checklist, extending its use to include minor surgery.
- Build on recent improvements in antimicrobial prescribing, in line with updated trust guidelines.
- Improve the prescribing of patient medicines on admission to hospital via the medicines reconciliation process.
- Carry out further review and analysis of specialty-specific readmission data.
- Implement changes following evaluation of clinical handover practices within the trust and carry out re-audit.
- Reinforce learning from the results of on-going trust-wide clinical documentation audit with invited presentation from a legal expert.
- Initiate a pilot project to audit points along the patient pathway in relation to consent and patient documentation.
- Review and expand the therapies clinical outcomes and patient experience programme and implement appropriate actions relating to treatment and management.

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by QVH in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 518, which was a significant increase from 2013/14.

Participation in clinical research demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest treatment possibilities and our active participation in research promotes improved patient outcomes.

QVH was involved in conducting 36 clinical research studies in 2014/15, involving clinical staff in four medical specialties as well as professions allied to medicine.

Use of the Commissioning for Quality and Innovation payment framework

A proportion of QVH income in 2014/15 was conditional on achieving quality improvement and innovation goals agreed between QVH and any person or body it entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further detail of the agreed goals for 2014/15 and for the following 12 month period are available online at http://qvh.nhs.uk/assets/publication/CQUIN2015.pdf.

The monetary value attached to achieving CQUINs for 2014/15 was £1,335,738.

A plan to achieve CQUINs was agreed with our commissioners and reported on quarterly. We achieved all our quality initiatives relating to CQUIN in 2104/15 and payment in full has been confirmed by our commissioners.

Care Quality Commission registration and periodic and special reviews

QVH is required to register with the Care Quality Commission (CQC) and its current status is 'registered'. QVH has the following conditions on registration: regulated activity takes place at QVH.

The CQC has not taken enforcement action against QVH during 2014/15. QVH has not participated in a routine inspection by the CQC during 2014/15. QVH has not participated in any special reviews or investigations by the CQC during the reporting period.

Data quality

QVH submitted records during 2014/15 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS number was:

- 99.5% for admitted patient care
- 99.7% for outpatient care
- 98.4% for accident and emergency care.

- which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care
- 100% for outpatient care
- 100% for accident and emergency care.

QVH's overall information governance assessment report score for 2014/15 was 82% and was graded satisfactory.

QVH was not subject to the payment by results clinical coding audit during the reporting period by the Audit Commission. However, the trust did commission an external audit of clinical coding for internal assurance purposes. The audit was based on the methodology detailed in the current version 8.0 of the Clinical Coding Audit Methodology set out by the NHS Classifications Service, using approved clinical coding auditors, adhering to the clinical coding auditors' code of conduct.

Part 3: Review of quality performance 2014/15

QVH has well-embedded processes for ensuring that patient safety, clinical effectiveness and patient experience are reported on in respect of all of its services. Progress against our key quality indicators and those mandated are shown below. Information on the delivery of operational performance targets, feedback from patients, complaints and national surveys have contributed to the identification of our additional priorities for 2014/15. Within the patient safety, effectiveness and experience sections, mandated data (marked '*') is included along with the rationale and actions being taken to improve scores.

Patient safety

At QVH we continue to focus on patient safety as our main priority in our pursuit of high quality care for all our patients.

Monitoring the prevention of harm and the rigorous investigation of all patient harm and clinical incidents provides opportunities to learn and minimise the risks of similar events happening again. Patient safety is included within our key strategic objective of 'outstanding patient experience' where patients are 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.

Our approach to safe care is supported by our risk strategy and our approach of looking consistently at the care we deliver with the aim of reducing harm to patients. Examples of patient safety initiatives we have implemented during 2014/15 are the Manchester Patient Safety Framework (MaPSaF) and Sign up to Safety.

We investigate all incidents, including all deaths and complications. The incidents are classified according to national guidance and reported on local and national databases. One incident during 2014/15, relating to an orthodontic issue, was classified as a never event. An immediate review of the incident and full investigation identified several areas of learning which have been shared widely throughout the orthodontic and maxillofacial teams. The findings from this never event and from other incidents are discussed at regular clinical directorate meetings and where there is significant learning this is shared at bimonthly joint hospital clinical audit meetings.

At QVH we see continuous development of staff as key to delivering safe care. Other learning points and actions are shared with relevant staff groups and dissemination occurs through the directorate team meetings, clinical policy and quality and risk committees, clinical cabinet, and the board of directors. Several additional feedback mechanisms have also been developed during 2014/15 including a risk management newsletter, feedback message to incident reporters on the outcome of investigations and a junior doctors' forum.

We take hospital acquired infection very seriously at QVH. This year, while we have had no cases of Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemia (infection in the blood) or Escherichia Coli bacteraemia, we had one case of Clostridium difficile. A root cause analysis (RCA) was undertaken which found no avoidable cause. The trust had one positive Meticillin Sensitive Staphylococcus aureus (MSSA) blood infection. A RCA was completed, and the unanimous conclusion was an unavoidable infection. This case was reported to the Health Protection Agency (HPA).

During 2014 there was an outbreak of a highly resistant strain of MRSA colonisation (infection on the skin) which resulted in temporary closure to new admissions to the burns unit. During this time trust policies and procedures were reviewed. An action plan was formulated and a range of interventions took place including screening of staff for MRSA, extensive deep cleaning of the clinical environment and additional training for staff.

For all the patient safety measures below, QVH considers that this data is as described for the following reasons: data is routinely collected and reported through internal meetings and these figures reflect those used and reported throughout the year. In addition, our auditors routinely review our processes for producing data and have acknowledged its accuracy. The trust does however recognise the limitations on reporting against clinical incidents and the judgement in the classification of harm as these require a degree of judgement against a series of criteria. QVH reports all incidents that occur at the trust through to the national reporting and learning system noting that the reported figures are subject to reliance on staff reporting all incidents.

Patient safety indicator	How the data is collected	Our target	Benchmark	2012/13	2013/14	2014/15
Clinical incidents reported per 1000 patient spells (spell = inpatient stay)	Monthly analysis of Datix clinical incident reporting system	N/A	91 per 1000 specialist acute trusts NRLS benchmark (Oct 12 to Mar 13)	43 per 1000 patient spells	57 per 1000 patient spells	52 per 1000 patient spells G
Comment: We actively encourage staff to report all incidents that have, or have potential to have, an effect on patient safety. We operate an open reporting system to aid learning from incidents, and have implemented several new feedback mechanisms during 2014/15.						
***Number of clinical incidents reported that have caused patient harm (actual number)**	Monthly analysis of Datix clinical incident reporting system Rate of patient safety incidents reported	0	32% of all incidents reported (NRLS of specialist trusts Apr to Sep 2012)	18 incidents causing harm 16% of all reported incidents 3 causing moderate harm; 0 causing major harm or death	130 incidents causing harm 13% of all reported incidents 11 causing moderate harm; 0 causing major harm or death	133 Incidents causing harm 14% of all reported incidents 9 causing moderate harm; 2 causing major harm or death A
Comment: The NRLS database has not been update since October 13 - March 14. Our rate of reporting was 47.2 per 1000 compared with the median of 76.3 per 1000 patient spells and our number of clinical incidents that caused harm was 13.3% compared with median of 24.5%. Reporting of a large number of no/low harm incidents demonstrates a good governance and risk management culture within organisations. QVH has an active incident reporting and investigation culture and this is demonstrated within the metrics and committee reporting. In 2014/15 QVH had eleven serious incidents reported, which was an increase compared to previous years. All incidents were fully investigated, with findings reported to the quality and risk committee. None of the incidents resulted in death. We have taken the following actions to improve this score and so the quality of our services by raising awareness through the mandatory training programme of the harm caused to patients from various incidents in order to reduce the percentage of incidents resulting in harm.						
Hand hygiene (washing or alcohol gel use)	Internal monthly audit of the five moments of hand hygiene	95% local benchmark	N/A	98%	99%	98.4% G
Comment: Good hand hygiene is linked with a reduction in hospital-acquired infections. This measure has shown a consistent high standard over time. Monthly audits are undertaken in all clinical areas and any staff member noted not to be complying is challenged and reminded why compliance is required. Hand hygiene is also included in mandatory training.						
***VTE risk assessment (per cent of admissions)**	Health and Social Care Information Centre data	95% national target	96% national average (Jan 2015)	92.3%	100%	99.8% G
Comment: Patients undergoing surgery can be at risk of VTE (venous thromboembolism). Those assessed at risk can have the correct precautions, including compression stockings and low molecular weight heparin. The 'safety thermometer' provides wards with a rate of harm-free care provided to patients, an aspect of which includes the assessment of patients for VTE risk on admission and after 24 hours following admission, and takes into account whether any prescribed medications were administered. This information has been collected throughout the year and we have consistently outperformed both the national target and the national average.						
Nutritional assessment within 24 hours of admission	Monthly 'safety thermometer' audit (three-monthly internal audit for years prior to 2014/15	>90%	N/A	96%	88%	99% G
Comment: Maintenance of nutrition is important for physical and psychological wellbeing. When illness or injury occurs, nutrition is an essential factor in promoting healing and reinforcing resistance to infection and an assessment should be completed for all inpatients within 24 hours of admission.						
Theatre lists starting with a surgical team safety briefing	Monthly internal audit	>90%	N/A	93%	94%	99% G
Comment: The metrics used to monitor compliance with these indicators were amended as part of the 2014/15 CQUIN to provide more detailed information (this year three areas were measured for the 'time out' and two for the 'sign out', whereas only one had only been measured previously) thus some variation has been identified in the data comparison with 2013/14. A whole-team safety briefing with surgical, anaesthetic and nursing staff before theatre lists begin improves communication, teamwork and patient safety in the operating theatre. This area has become more embedded as routine practice and there will be a continued focus on this during 2015/16 with the aim of increasing and maintaining compliance at 100%.						

Patient safety indicator	How the data is collected	Our target	Benchmark	2012/13	2013/14	2014/15
Use of the WHO Safer Surgery checklist	Monthly internal audit	100% by 31/03/2015		Month 10	Month 11	Month 12
			Sign in	99.2%	98%	100%
			Time out	99.2%	96%	100%
			Sign out	98.3%	82%	100%
						A
Comment: The methodology that was used to measure performance against the WHO checklist was amended during 2014/15 as part of the CQUIN. During the first six months of 2014/15 we have had incidents that we know could have been prevented or identified earlier if we had higher compliance with both the 'time out' and 'sign out' aspects of the WHO safer surgery checklist. However, improved focus and embedding of the checklist in the latter part of 2014/15 has led to greatly improved compliance.						
Development of pressure ulcer grade 2 or over (per 1000 spells)	Internal audit	0	0.84/1000 admissions (SEC Jan12)	0.2/1000 spells (total number = 3)	0.5/1000 spells (total number = 8)	0.6/1000 spells (total number = 11)
						A
Comment: These figures are for hospital-acquired injury. We are disappointed that our rate has not decreased further this year. None of the pressure injuries sustained were graded as a level 3 or 4. The investigations showed that the main cause of injury was related to prolonged surgery where patients were undergoing complex surgery that lasted for more than four hours and in some cases over 13 hours. In 2015/16 we will be using a more detailed investigation tool to investigate all hospital acquired pressure ulcers. This new tool was developed in collaboration with the Sussex Serious Incident Review Panel and provides a standardised approach to reviews. Our quality and risk committee undertook a 'deep dive' review of pressure ulcer occurrences and investigations in January 2015 to assist in identifying any further preventative measures that could be taken. Pressure ulcer development in hospital is also measured through data collection for the national 'safety thermometer'.						
Patient falls, including falls associated with harm (actual number)	Internal audit	<1 per 1000 spells	2.2/1000 admissions (SEC SHA Jan 12)	64 falls 3.9/1000 spells 26 causing harm 1.6/1000 spells	49 falls 2.9/1000 spells 16 causing harm 0.9/1000 spells	50 falls 2.8/1000 spells 21 causing harm 1.2/1000 spells
						G
Comment: We have continued to use revised falls assessment procedures throughout 2014/15 and these include processes for alerting all staff to patients at risk. Our incidents of harm in this area have increased slightly which is disappointing, however no falls resulted in major harm or death, with the majority causing minor harm such as a scratch or graze.						
Number of reportable MRSA bacteraemia cases	Internal audit	1	N/A	2	0	0
						G
Comment: MRSA bacteraemias are a particular risk in patients with burns. No cases were acquired at QVH during 2014/15.						
***Number of reportable Clostridium difficile cases**	Health and Social Care Information Centre data	0	National average 2011/12 21.8/ 100,000 bed days (range 0-51.6)	Total = 0 0/100,000 bed days	Total = 1 0/100,000 bed days	Total = 1 5.46/100,000 bed days
						G
Comment: All Clostridium difficile is thoroughly investigated by root cause analysis. One case does not mean we breach our national target as a de minimis of 12 is set for Clostridium difficile. To improve infection control further we have reviewed our antibiotic and Clostridium difficile policies and proactively screen and manage our patients. The infection control team also continues to deliver training to staff on patient management and infection control.						

Patient safety indicator	How the data is collected	Our target	Benchmark	2012/13	2013/14	2014/15
Patients receiving all correct physiological monitoring during admission	Internal fortnightly audit of 10 patient records	>95%	N/A	96%	97%	99% G
Comment: Monitoring of pulse, blood pressure, respiratory rate, temperature, pain and sedation is important to detect and prevent physiological deterioration of patients. Our improving score shows that real-time monitoring and the ability to provide prompt feedback to staff has continued to improve patient assessment.						
Percentage of staff witnessing potentially harmful errors, incidents or near misses in the last month	National staff survey	To achieve or better acute trust specialist bench mark	29% national average acute specialist trusts 2014	31%	27%	29% G
Comment: We continue to engage with and empower our staff to report potentially harmful errors incidents or near misses so that we can investigate, understand, learn and improve.						
Percentage of staff uptake of seasonal influenza vaccine	Internal audit	>60%	National rate 46% 2012/13	52.3%	55%	52.6% A
Comment: Frontline (clinical and non-clinical) staff uptake of influenza vaccine is important in ensuring that the organisation is able to maintain services during an influenza outbreak and supports delivery of our emergency and business continuity plans. We fell short of the 60% target. However we performed well when compared with uptake across England at 54.9% (provisional data) and 44.7% across Surrey and Sussex. We will continue to take a proactive approach, providing roving clinics as a part of the vaccination programme and other open sessions for all staff.						

Clinical effectiveness

As a specialist hospital, we provide a very specific range of surgical treatments. As a result of this, many of the national measures and audits of clinical effectiveness will not apply to us as they tend to focus on the more common conditions that patients attend hospital for such as diabetes and common cancers. QVH is collecting measures of its own specific treatment outcomes so that clinicians, patients, our commissioners and other stakeholders can be assured that the treatments our consultants and medical staff offer are of the highest quality.

There are other means to quality assure our data, both national and locally driven, including the incorporation of guidance from the National Institute for Health and Care Excellence (NICE), other national audit and outcomes measures such as the National Confidential Enquiry into Perioperative Death and locally-driven audits of specific practice at QVH. We have an audit team which works with our clinicians of all grades to ensure audit is relevant and that improvements feed back in to clinical practice.

Within the patient safety, effectiveness and experience section of our quality accounts there is mandated data (marked '*'). QVH has not provided summary hospital-level mortality indicator (SHMI) data for the trust as this is not collected by the Health and Social Care Information Centre (HSCIC). As QVH is a specialist trust we have therefore included our own trust in-hospital surgical mortality information. Other information that is not relevant to QVH, so has been excluded from the information provided, is palliative coding information and specified patient reported outcome measures. QVH has collected some outcome measures on specialist areas and where these are available they are included.

For all clinical effectiveness measures QVH considers that this data is as described for the following reasons: data is routinely collected and reported through internal meetings and these figures reflect those used throughout the year. In addition, our auditors routinely review our processes for producing data and have acknowledged its accuracy.

All specialties						
Clinical effectiveness indicator and why we measure it	**How we measure it**	**Target**	**Benchmark**	**2012/13**	**2013/14**	**2014/15**
We aim to take patient consent for elective surgery prior to the day of surgery at QVH	Monthly internal audit	>75%	N/A	48%	72%	74.3% A
Comment: Good progress has been made this year and while we did not quite achieve the target set of 75% we will continue to measure and ensure that this measure is seen as a priority and a mark of good practice.						
In-hospital surgical mortality	Continuous monitoring of PAS data	N/A	N/A	2012 0.007%	2013 0.007%	2014 0.007% G
Comment: Because of our specialist work it is not possible to present a comparable hospital standardised mortality ratio. We do, however, monitor death rates in burns care and surgery. The death rate presented here represents only one surgical death this year. One death can make a significant difference to the trust's mortality rate. All deaths at QVH are reviewed within specialties and in a multidisciplinary forum.						
***Percentage of patients aged 0-14 readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period**	Health and Social Care Information Centre data	N/A	England 2011/12 10.01 (range 0.00 to 14.94) Acute specialist trust data not grouped this year	2012/13 Not yet available from HSCIC	2013/14 Not yet available from HSCIC	2014/15 HSCIC report it is unlikely data will be published this year due to moving the system in-house G
Comment: In the absence of national data QVH collates all emergency readmission data and a monthly report is produced and circulated trust-wide. Individual cases are discussed as part of the departmental mortality and morbidity review meeting and learning points may be forwarded to the clinical audit team to facilitate wider learning within the organisation.						
***Percentage of patients aged 15 and over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period**	Health and Social Care Information Centre data	N/A	England 11/12 11.45 (range 0.00 to 53.31) Acute specialist trust data not grouped this year	2011/12 16 and over 9.64	2012/13 Not yet available from HSCIC	2013/14 Not yet available from HSCIC G
Comment: In the absence of national data QVH collates all emergency readmission data and a monthly report is produced and circulated trust-wide. Individual cases are discussed as part of the departmental mortality and morbidity review meeting and learning points may be forwarded to the clinical audit team to facilitate wider learning within the organisation.						
Unexpected return to theatre within 7 days	Continuous monitoring of PAS data	<1%	N/A	2012 1.02%	2013 1.05%	2014 0.7% G
Comment: A patient may have to unexpectedly return to theatre because of post-operative bleeding, infection or other complication. There is a decrease in the return to theatre rates however we are undertaking further analysis of our data to ascertain whether this is an increase in low complexity activity (which has a much lower rate of return) or actual improvement in the complex case returns rate.						

All specialties						
Clinical effectiveness indicator and why we measure it	**How we measure it**	**Target**	**Benchmark**	**2012/13**	**2013/14**	**2014/15**
Unexpected readmission to QVH within 28 days following discharge	Continuous monitoring of PAS data	<1.5%	N/A	2012/13 1.48%	2013/14 1.29%	2014/15 1.3% G
Comment: All unexpected readmission data is circulated monthly. Individual cases are discussed as part of the departmental mortality and morbidity review meeting and learning points may be forwarded to the clinical audit team to facilitate wider learning within the organisation.						
Unplanned transfer out of QVH for additional care	Internal audit	<0.5%	N/A	2012 0.27%	2013 0.33%	2014/15 1.3% G
Comment: We are supported by surrounding trusts in the provision of specialist services (such as respiratory medicine and cardiology) which we are unable to provide. We monitor our rates of unplanned transfer to surrounding trusts for these services. All clinical speciality groups are provided with the details of individual cases for analysis and review.						

Burns service

In 2014 the burns service accepted 1,007 adult (>16 years of age) referrals. This is an increase from 886 in 2013. Of these, 201 patients required inpatient care and 29 of these needed treatment in our critical care unit. Of the referrals, 32 of the patients were accepted for specialist surgical reconstruction required due to significant skin loss from causes other than burns (e.g. necrotising fasciitis). Eight patients received specialist rehabilitation care in our dedicated 'burns rehabilitation flats' facility.

QVH accepted 943 paediatric burns referrals during 2014, an increase from 756 in 2013. Of these, 73 patients required inpatient care on our paediatric ward.

Survival rate

In 2014 fewer than five adult burns patients died (actual figure not given to protect patient confidentiality). This equates to a burns inpatient mortality rate of <5%. There were no paediatric deaths. All patient deaths are discussed at burns multidisciplinary governance meetings so that any learning points can be built upon. If it is thought, either by the team or by the clinical audit lead that further review and discussion is required, then the patient's case is subsequently presented at a joint hospital clinical audit meeting.

Clinical effective indicators

Patients likely to exceed our targets for healing are discussed in the multidisciplinary team meeting and reviewed by a burns consultant with a view to proceeding to surgery to close the wound. Patients may, after discussion, decide not to proceed with surgery. Equally, at these meetings, the care pathways of all inpatients whose stay seem likely to exceed or has exceeded their target length of stay are discussed. The national burns outcome group has adjusted the target for healing times for patients over 65 years old to under 31 days due to additional issues which may impede healing. We have therefore reanalysed data for 2013/14.

Clinical effectiveness indicator and why we measure it	**How the data is collected**	**Target**	**Benchmark**	**2012**	**2013**	**2014**
Adult burn wounds healing within 21 days if patient under 65 years	Prospective database of adult burns	100%	N/A	73%	62%	64%
Adult burn wounds healing within 31 days if patient over 65 years		100%	N/A		50%	59%
Average time for adult burn wound healing (median)		< 21 days	N/A	14 days	17 days	16 days
Paediatric (<16 years) burn wounds healing within 21 days	Prospective database of paediatric burns	< 21 days	N/A	N/A	88%	88%
Average time for paediatric burn wound healing (median)		<21 days	N/A	16 days	16 days	10 days
Comment: Burns healing in less than 21 days are less likely to be associated with poor long-term scars. A shorter burn healing time may reflect better quality of care through dressings, surgery and prevention of infection. Some data on healing time could not be collected particularly when patients do not attend for follow-up or care is transferred. The absence of this data could mean several things. It could be assumed that patients who do not attend for appointments do not require further treatment and so healing times could be reduced. Patients transferred to other providers may be due to prolonged healing time or the development of chronic wounds which are most commonly treated in the patient's local area rather than a supra-regional service such as QVH.						

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2012	2013	2014
Average length of adult inpatient stay (bed days) per percentage burn for acute injury admissions	Prospective database of adult burns	<65 years old - 1 day per 1% burn	N/A	1.5 days	1.6 days	1.6 days
		>65 years old - 2 days per 1% burn	N/A	2 days	3.6 days	2.7 days
Average length of paediatric inpatient stay (bed days) per percentage burn for acute injury admissions	Prospective database of paediatric burns	<16 years - 2 days per 1% burn	N/A	0.8 days	1.1 days	0.6 days

Comment: The target length of inpatient stay of burns patients is related to the size of their burn, measured as a percentage of their body surface area. We aim that, on average:

- Adult patients between the ages of 17 and 65 years of age should require a one-day inpatient stay per 1% burn.
- Adult inpatients over 65 years should require a two-day inpatient stay per 1% burn. Over 65 the length of stay is often complicated by the higher prevalence of co-morbidities among this age group and the requirement for complex social care packages which take time to arrange.
- Paediatric inpatients between 0 and 16 years of age should require a two-day inpatient stay per 1% burn.

Plastic surgery – breast surgery, hand surgery, skin cancer care and surgery

Our plastic surgery clinical directorate is one of the largest in the country and generates a significant part of the surgical activity within the trust. Our team of 19 specialist consultants is supported by a wider network of junior surgeons, specialist nurses, occupational therapists, physiotherapists and speech and language therapists.

Breast surgery

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

Breast reconstruction after mastectomy using free tissue transfer – flap survival

The gold standard for breast reconstruction after a mastectomy is a 'free flap' reconstruction using microvascular techniques to take tissue, usually from the abdomen, and use it to form a new breast. This technique has greater patient satisfaction and longevity but can carry greater risks than an implant or pedicled flap reconstruction, so it is important we monitor our success both in terms of clinical outcome and, equally importantly, how the women feel throughout the reconstructive journey. The latter is a patient reported outcome measure (PROM). If the abdomen is insufficient then tissue can be used from the inner thigh or the bottom as a free flap for breast reconstruction. Anita Hazari has been instrumental at a national level in the setup, design and implementation of a national free flap registry which will include PROMs.

In 2014 the breast team performed a total of 230 flaps. This is a 22.3% increase on 2013. Of these, 113 flaps were from the abdomen and 17 were from the thigh. Breast reconstruction was performed immediately after the mastectomy in 43% of cases, representing a year-on-year increase from 39% in 2013 and 26.3% in 2012. This is part of an increasing trend towards immediate reconstruction where possible.

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2012/13	2013/14	2014/15
Breast reconstruction after mastectomy using free tissue transfer – flap survival	Continuous prospective electronic database	100%	95–98% (published literature) 98% BAPRAS 2009	99.44%	98.94%	100%

Comment: Our total failure rate was zero, this compares favourably with last year (1.06%). This is well below the national quoted rates of 2%.

Plastic surgery – breast surgery, hand surgery, skin cancer care and surgery (continued)

Hand surgery

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

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

The geographical intake for acute trauma comes from most of the south east of England and southeast London and covers all aspects of hand and upper extremity trauma. QVH offers a 24-hour trauma service with access to two dedicated trauma theatres for inpatient and day-case procedures.

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2012/13	2013/14	2014/15
Rupture rate following repair of flexor tendon injuries (% of tendons)	On-going monthly audit between hand surgeons and hand therapists, with complication data collected via a trauma database	<5%	5% Local QVH bench mark	5%	2% QVH flexor tendon audit	4%

Comment: Hand surgery accounts for nearly 80% of the trauma workload of the hospital, with flexor tendon repair the most common injury requiring surgery. In 2014 we carried out 208 primary repairs of flexor tendon injuries. Monitoring rates of rupture of the repaired tendon is one way of monitoring quality of surgery and postoperative therapy.

Skin cancer care and surgery

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

Clinical effectiveness indicator	How the data is collected	Target	Benchmark	2012/13	2013/14	2014/15
Complete excision rates in basal cell carcinoma (BCC)	Audit of two months activity (275 BCC cases)	100%	88.9 – 95.3% (published literature)	91.7%	92.5%	94.1%

Comment: BCC is the most common cancer in Europe, Australia and the USA. Management usually involves surgical excision, photodynamic therapy (PDT), curettage, immuno-modulators, or a combination. Surgical excision is highly effective with a recurrence rate of 2%. Complete surgical excision is important to reduce recurrence rates. This may not be possible because of the size or position of the tumour or because the incomplete excision will only be evident with histological examination of the excised tissue. The high rate of complete excision for QVH is particularly pleasing as 40% of our referrals are from dermatologists who refer more complex cases. In 2014, 1,386 BCCs were removed at QVH.

Clinical effectiveness indicator	How the data is collected	Target	Benchmark	2012/13	2013/14	2014/15
Complete excision rates in malignant melanoma	Audit of two months activity (41 melanoma cases)	100%	75% (NICE guidance)	95.6%	96.5%	96.1%

Comment: Melanomas are excised with margins of healthy tissue around them, depending on the type, size and spread of tumour. These margins are set by national and local guidelines and each case is discussed in a multidisciplinary team (MDT). Total excision may not be possible because of the health of the patient or the size, position or spread of the tumour, and the MDT may recommend incomplete excision. In 2014/15 229 melanomas were removed at QVH.

Head and neck, including head and neck oncology, orthognathic and orthodontic surgery

Head and neck

Our head and neck services are recognised, regionally and nationally, for the specialist expertise offered by our large consultant body. In particular, QVH is the Kent and Sussex surgical centre for head and neck cancer and is recognised by the Royal College of Surgeons as a training centre for Training Interface Fellows in Advanced Head and Neck Oncology Surgery.

Clinical effectiveness indicator	How the data is collected	Target	Benchmark	2012/13	2013/14	2014/15
Number of new cases	Review of all new head and neck oncology patients' notes and data entry 2013/14 figures are an average of the previous two years submission for the National Head and Neck Cancer Audit			N/A	58	55
New diagnoses where pre-treatment was discussed at an MDT meeting		100%	99.9%	N/A	86%	100%
Cases where surgical resective pathology results were discussed at an MDT meeting		100%	98.6%	N/A	100%	100%

Comment: The cases included are all new diagnoses of the six most frequent head and neck cancers in England (larynx, oral cavity, oropharynx, hypopharynx, major salivary gland, and nasopharynx) which underwent major head and neck surgery (as per a defined list of procedures) as first definitive treatment (excludes nasal cavity, bone tumours and ear cancers).

Discussion of the diagnosis and management of head and neck cancer at a multidisciplinary team (MDT) meeting is considered a standard of care and all new cases should be discussed. This is a peer review standard.

The information has been derived from the National Head and Neck Cancer Audit (DAHNO) based on date of MDT discussion and date of surgery supplemented by surgeon entry. 99.9 % of cases having major surgery have pre-treatment discussed at MDT status recorded. The recorded measure of 86% for 2013/14 taken from DAHNO, is a misrepresentation and we believe the figure to be 100%, but have included this record in the interest of transparency and alignment with nationally published data.

Orthognathic treatments

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

Clinical effectiveness indicator	How the data is collected	Target	Benchmark	2012/13	2013/14	2014/15
Facial nerve injury rates in condylar fracture (jaw fracture) repair	Trauma Card (continuous trauma and complications database)	0%	17%	5.8%	0%	12.5%

Comment: This small scale audit (eight patients in 2014/15) is consistent with low nerve injury demonstrated in several previous published audits from the department which confirm a very low rate of facial nerve injury following operative intervention for fractures of the condylar neck. We monitored the damage to the facial nerve during open reduction of mandibular fractures. This is particularly pertinent to condylar fractures which we offer open reduction in a number of cases, permanent nerve injury rate is 0, and has been for a number of years. We have never had a case of permanent nerve injury in over 100 fracture repairs.

We have suspended monitoring of nerve injury rates in third molar extraction as the number of cases with nerve injury is very small and distinguishing and defining temporary nerve injury is very subjective.

Clinical effectiveness indicator	How the data is collected	Target	Benchmark	2012/13	2013/14	2014/15
How do you rate the orthodontic service and care?	Patient questionnaire	N/A	N/A	90% excellent 10% good	83% excellent 17% good	88% excellent 12% good
How do you rate the quality of surgical care?		N/A	N/A			91% excellent 8% good 1% average
How satisfied are you with facial appearance?		N/A	N/A	74% very satisfied 26% satisfied	71% very satisfied 28% satisfied 1% neither satisfied nor dissatisfied	68% very satisfied 29% satisfied 3% neither satisfied nor dissatisfied
How satisfied are you with dental appearance?		N/A	N/A	85% very satisfied 15% satisfied	72% very satisfied 27% satisfied 1% neither satisfied nor dissatisfied	80% very satisfied 20% satisfied

Comment: We continue to undertake a large number of orthognathic procedures with over 750 cases recorded consecutively on our orthognathic outcome database. Results demonstrate a very high level of satisfaction with both orthognathic surgeons and the specialist orthodontists who work together as a team. We have used patient outcome data for recorded surgery after 1 April 2013. The reason for this is that orthognathic treatment is approximately a three year process, with the surgery approximately one year before the end of treatment. Using this method we get an approximation of in year data quality (the results reflect data collected in 2014/15 year for patients operated in the year 2013/14).

Clinical effectiveness indicator	How the data is collected	Target	Benchmark	2012/13	2013/14	2014/15
Fractured mandible operated by next working day	Annual audit	90%	72.2%	N/A	N/A	50%
Median time to theatre		N/A	22h 44m	N/A	N/A	36h 49m

Comment: QVH has contributed to a national audit of mandible facture trauma services conducted by the British Association of Oral and Maxillofacial Surgeons. The aim is for all eligible patients to be operated on the same or next day. Not all patients can be operated on the same day or the next day if they are medically unfit or if they have other injuries which take priority. We recognise that for many of our patients, we are not the first hospital they attend, and that they are referred to us due to our specialist nature. This may add many hours, in some cases days, to their time to treatment. This is the first time QVH has reviewed this indicator and we recognise that improvement will need to be made.

Clinical effectiveness indicator	How the data is collected	Target	Benchmark	2012/13	2013/14	2014/15
Peer Assessment Rating (PAR) index for orthodontic treatment	Continuous prospective data collection on all orthodontic patients	N/A	>70% = very high standard <50% = poor standard	95%	95%	97%

Comment: The PAR (Peer Assessment Rating) index provides an objective measure to assess the improvement gained by orthodontic treatment. The higher the PAR score, the poorer the bite / occlusion. Data is collected prospectively for all orthodontic patients following treatment. The results fall into one of three clearly defined categories: greatly improved, improved and worse/no different. With respect to interpreting the results, a mean PAR score improvement of greater than 70% represents a very high standard of treatment.

For QVH, 97% of our patients were assessed in the first two categories with 52% in the greatly improved category. These results are well in excess of national average figures and demonstrate very good outcomes in the orthodontic department at QVH. Patients whose outcomes do not improve as we would like are investigated by the team on an annual basis and a root cause analysis undertaken so we can improve future care for others wherever possible.

Clinical effectiveness indicator	How the data is collected	Target	Benchmark	2012/13	2013/14	2014/15
% of patients who were completely/fairly satisfied	Patients asked at the end of treatment to complete a questionnaire in hospital and review their whole treatment period	95%	N/A	N/A	100%	100%
% of patients agreeing teeth were as straight as hoped for		95%	N/A	N/A	97%	98%
% of patients glad they had the treatment		95%	N/A	N/A	97%	98%
Comment: Every patient who has finished orthodontic treatment completes a questionnaire privately and digitally, directly into our outcomes kiosk. In addition to the key PROMs detailed above, 94% of patients were happy with the appearance of their teeth after treatment, 84% reported improved self-confidence, and 94% would recommend a similar course of treatment to a friend.						

Mandibular advancement splint (new measure)

QVH has one of the largest dedicated sleep centres in the UK responsible for the treatment of sleep disordered breathing. There is close liaison with the sleep centre and the orthodontics department which receives up to 400 referrals each year. Treatment involves a non-invasive intra-oral appliance known as a MAS (mandibular advancement splint) which can improve the quality of sleep in mild to moderate sleep apnoea. Patients receive a suitability screen prior to referral to QVH. Previous audits have shown an 85% success rate. We aim to identify those patients who are most likely to benefit from a MAS by identifying clinical parameters that will most likely respond positively to this treatment. The primary aim of the audit was to:

- measure satisfaction with MAS
- measure subjective improvement in apnoea/daytime sleepiness
- identify areas where we can improve our service.

The audit consisted of an electronic patient satisfaction questionnaire given to patients on the day of discharge. Fifty consecutive patients were enrolled and data collection commenced in May 2014 and concluded in March 2015.

Clinical effectiveness indicator	2014/15
% of patients who wore their appliances at least four times a week or more	88%
% of patients who were snoring less than before	50%
% of patients experienced aching teeth and jaws which resolved following regular wear of the appliance	69%
% of patients who experienced resolution of their apnoeic symptoms	80%
% of patients who claimed a general feeling of well-being following splint therapy	92%
% of patients who claimed that their daytime sleepiness had improved	78%
% of patients who claimed their sleep quality had improved	78%
Comment: There was an 80% resolution in apnoeic symptoms.	

Corneoplastic and oculoplastic surgery

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

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

Clinical effectiveness indicator	How the data is collected	Target	Benchmark	2012/13	2013/14	2014/15
Percentage of patients achieving vision better than 6/12 after cataract surgery without other eye disease	Annual audit of 100 patients	100%	96% (UK EPR)	100% with correction 90% unaided	100% with correction 90% unaided	100% with correction 92% unaided
Comment: There were 1,106 cases of phacoemulsification for cataracts recorded in 2014. Departmental audit shows that cases of post-operative eye infection are extremely rare and well below national average rates. We monitor the number of these patients who achieve significant improvement to the vision in that eye.						

Sleep

The Sleep Disorder Centre was established in 1992 and provides a comprehensive sleep medicine service for the south east of England. It employs 25 staff, including three consultant physicians and nine technicians, supported by administrative staff and secretaries. The centre diagnoses and treats all aspects of adult sleep medicine although respiratory disorders during sleep constitute the largest part of the workload. These include sleep disordered breathing (SDB), hypoventilation syndromes (mostly related to increased body mass index), insomnia, NREM parasomnias, REM behaviour disorder, sleep related movement disorders, sleep related epilepsies and circadian rhythm disorders.

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

Although bed partners will observe and complain about sleep disordered breathing, the individual is usually unaware of their condition, but may notice a decline in daytime function and motivation, often accompanied by excessive daytime sleepiness. Measuring daytime sleepiness is therefore an easy marker of symptoms. One commonly used scoring system is the Epworth Sleepiness Scale (ESS), a questionnaire that assesses the likelihood of accidently falling asleep whilst undertaking eight common daily activities.

Patient reported outcome measures (PROMs) include assessing the patient's subjective improvement in daytime sleepiness and function using the ESS, and are therefore effective indicators of the efficacy of therapy.

Clinical effectiveness indicator	How the data is collected	Target	Benchmark	2012/13	2013/14	2014/15
Percentage reduction in daytime sleepiness - pre/post Epworth Sleepiness Score (mean score)	Demographically representative random audit of 100 patients using CPAP equipment	N/A	N/A	N/A	N/A	59%
Drop in Epworth Sleepiness Score amongst patients with an initial score higher than 10 (mean score)		N/A	N/A	N/A	N/A	10.3%

Comment: This is the first time this audit has been completed in this way at QVH. We will regularly measure the ESS to ensure patients continue to benefit from this treatment. Sleep at night is essential for good health and excessive sleepiness during the day reduces quality of life and is associated with harm to individuals (such as falls and driving accidents). The respiratory dysfunction which can be associated with these symptoms can also cause hypertension and the onset of diabetes which can also lead to cardiovascular sequelae.

Anaesthetics

We have 19 consultant anaesthetists at QVH with supporting staff in the operating theatres, high dependency unit and in the burns centre. The department has pioneered and developed special expertise in dealing with patients with abnormal airways due to facial deformity, techniques to lower blood pressure and reduce bleeding during delicate surgery, and the use of ultrasound for the placement of regional local anaesthetic for the upper limb.

Clinical effectiveness indicator	How the data is collected	Target	Benchmark	2012/13	2013/14	2014/15
Percentage of patients requiring no recovery room intervention following anaesthesia	Continuous prospective audit of all inpatient recovery room procedures. 2014/15 data relates to data from Feb-Mar 2014 and Jun-Dec 2014	100%	N/A	84%	88%	88%

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

Patient experience

We place great importance on ensuring our patients have an excellent experience. We continue to develop ways to engage and listen to our patients, collecting views, comments and ideas from them, their families and carers which then form our future plans to further improve patient experience. In 2014/15 QVH has seen a number of national surveys at the hospital including cancer, paediatric and in-patient services.

We use survey results to help us focus on what really matters to patients to improve their hospital stay. The results of the 2014 national inpatient survey were published in April 2015. The survey was completed by 405 patients who had stayed at QVH for at least one night during June, July or August 2014. This is a response rate of 49% compared to a national average of 45%.

In the survey, QVH scored significantly better than other trusts on 41 of the 58 questions, about the same on 16 and worse than average on only one. QVH achieved the top scores in the county for ten of the questions including questions around:

- Patients' overall experience of the hospital
- The emotional support patients received from the hospital staff
- Whether staff did all they could to control pain
- Whether there were enough nurses on duty
- The cleanliness of hospital room and wards.

The only question on which QVH scored worse than average was about the choice of hospital food and we are acting on these results and have selected improving patient experience of QVH prepared food as one of our 2015/16 quality account priorities.

The patient experience group has continued with regular meetings, chaired by the director of nursing and quality. The group looks at all information relating to patient experience at the hospital and has made a number of changes as a result, for example appointment and reminder letters have been revised as a result of patients' feedback that they could be improved.

For outpatients, waiting for a clinic appointment can be a stressful time and we continue to look at ways to improve communication with patients to reduce the anxiety while waiting to be treated. The plasma screens in our main outpatients clinic help promote health awareness in general and notify patients if there are delays to a clinic, which is now displayed alongside live TV.

Patient experience indicator	How the data is collected	Target	Benchmark	2012/13	2013/14	2014/15
Failure to deliver single sex accommodation (occasions)	Internal continuous audit	0	N/A	0	0	0 G
Comment: In all wards, outside of theatre recovery areas and critical care, we endeavour to deliver care in male and female segregated wards or bays. Failure to meet this requires formal reporting. We are pleased to have been able to maintain segregated accommodation during 2013/14 and this has been achieved because we have a number of single rooms available for use.						
Complaints per 1000 spells	Continuous internal audit	<5 per 1000 spells	N/A	4.4	4.7	4.1 G
Comment: Formal complaints indicate that the high-quality care we aim for has not been delivered. For this reason we take complaints very seriously. All complaints are investigated and reviewed by the executive team. If the complainant remains dissatisfied we will actively support them in going to the ombudsman for assurance that their complaint has been responded to appropriately. Historically, we have performed well against complaints indicators and have taken reassurance that any complaint that has been referred to the ombudsman has not been accepted for investigation or upheld. During the year considerable effort has been made to improve how we manage complaints by responding to complainants on a more personal level and by improving the quality of responses.						
Claims per 1000 spells	Continuous internal audit	<1	N/A	0.7	1.0	1.2 G
Comment: This reflects legal action against the trust by patients or carers, and includes all cases, whether founded or unfounded. All findings from claims are fed back to the consultant involved. During the past two years we have made this information widely available through our joint hospital audit meeting so that others can learn from incidents where a claim is upheld.						
Overall experience	National inpatient survey	>9	Range 7.1-9.1 2013	9.0	8.9	9.2 G
Comment: We are pleased to have achieved the highest score in the country for overall patient experience.						

Patient experience indicator	How the data is collected	Target	Benchmark	2012/13	2013/14	2014/15
Dignity and respect	National inpatient survey	10	9.7 highest national score 2013	9.6	9.6	9.7 G
Comment: Patients continue to report that they are treated with dignity and respect at QVH.						
PLACE scores (Replace the PEAT scores used in 2012)	National Reporting Learning Service	N/A	National average 2014	2012 Environment: Good		
Cleanliness			97.3%	Food: Excellent	98.9%	98.45%
Food			86.1%		81.3%	83.77%
Privacy, dignity and wellbeing			87.7%	Privacy and dignity: Excellent	91.2%	82.66%
Condition, appearance and maintenance			92%		90.7%	89.85% A
Comment: PLACE is an annual assessment of inpatient healthcare sites in England with more than ten beds. It is self-assessed and inspects standards across a range of factors including food, cleanliness, infection control and patient environment (including bathroom areas, décor, lighting, floors and patient areas). Overall we scored well although food is noted – both through this assessment and patient surveys - as an area where we can improve further.						
***Responsiveness to inpatients' personal needs**		> 82	76.9 national average 2013 Surrey & Sussex Area Team (range 72.8-86.3)	88.2	86.3	Awaiting HSCIC update (last refreshed Sept 2014) G
Comment: This is an amalgamated score from five questions within the national NHS inpatient survey. QVH continues to monitor staff awareness of the expectation that delivering excellent care should be a priority for everyone, and now has in place awareness sessions within the local induction programme linked to the Chief Nursing Officer's 6Cs.						
***NHS friends and family test - acute inpatients**	NHS friends and family test average score over the year	>80%	2013-14 range for acute specialist trusts 62-97	N/A	86	Likely / very likely to recommend 99% Unlikely / very unlikely to recommend 0.25%
***NHS friends and family test - minor injuries unit**	NHS friends and family test average score over the year					Likely / very likely to recommend 86.5% Unlikely / very unlikely to recommend 2.1% G
Comment: All patients discharged from an adult inpatient ward are given a questionnaire asking if they would recommend QVH to their friends and family based on their experience in the hospital on a scale from 'extremely likely' to 'extremely unlikely'. Patients also have an opportunity to give reasons for their answer. We also give the questionnaire to patients who have visited our minor injuries unit. From October 2014 FFT scoring changed and now uses the percentage of respondents that would be likely / very likely to recommend and unlikely / very unlikely to recommend the service in place of the previous 'net promoter score', which some people found difficult to interpret so comparison with previous years results is not applicable.						

Patient experience indicator	How the data is collected	Target	Benchmark	2012/13	2013/14	2014/15
Percentage of patients who rated their quality of care as good or excellent	NHS friends and family test	>95%		99%	98%	98% G
Comment: As part of the NHS family and friends test question we invite all inpatients to complete a questionnaire about their quality of care on discharge and specifically ask 'overall, how would you rate the quality of the care you were given?' We work very closely with our clinical staff to ensure that all possible options are fully discussed with patients to enable them to make decisions about treatment and care options.						
Percentage of patients who reported sufficient privacy when discussing their condition or treatment	National inpatient survey 2014	Local target >90%	95% highest score achieved in national inpatient survey 2013	95%	86%	90% G
Comment: That patients felt their privacy was respected when discussing their condition is a key measure of the quality of care delivered. We are pleased that this scored has significantly improved.						
Satisfaction with anaesthetic service	National inpatient survey 2014	>9	9.6 highest score achieved in national inpatient survey 2013	9.6	9.2	9.6 G
Comment: We have taken information on satisfaction with our anaesthetic services from the national inpatient survey and the question 'Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?'						
***Staff recommendation of the trust as a place to work or receive treatment**	National staff survey	>4	4.08 national average acute specialist trusts 2013 (highest 4.33)	4.24	4.26	4.16 (national average acute specialist trusts 2014 was 4.12) G
Comment: The data is taken from the NHS staff survey results and shows QVH continues to be better than the national average. We are currently undertaking an in-depth review of the last three years of staff surveys to identify trends and formulate an action plan to further improve staff engagement and experience.						

National and local quality indicators for external audit

For 2014/15 QVH is required to provide assurance from external auditors that two mandated indicators included in the quality report have been reasonably stated. The two national mandated indicators for QVH which have been agreed by the audit committee and with the external auditors KPMG are:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

In addition, the external auditors are required to review a local quality indicator selected by the trust governors. The senior management team prepared a short-list of options for the governors and cancelled operations was selected, and was confirmed as auditable by KPMG.

Patient safety indicator	How the data is collected	Target	Benchmark	2012/13	2013/14	2014/15
Cancer						
62 day wait from referral to definitive cancer treatment	Data is collected monthly and reported quarterly. Information is obtained through tracking patients from referral to definitive cancer treatment and includes liaison with other shared care providers.	85%	85%	92.5%	89.3%	87%
18 weeks						
Incomplete pathways	Data is collected and reported one month in arrears monthly via the RTT waiting list for 18 weeks which has been validated.	92% per month	92%	94%	93.8%	93.5%
Cancelled operations						
All patients cancelled each month, for non-clinical reasons regardless of when they were cancelled.	Data is collected from the PAS systems and reported each month. Data is collected from information contained with the theatre system and then validated before being reported monthly. The compliance with 28 days is monitored and recorded via information from theatres and PAS systems.	<118 per month for Q1; less than 79 per month for Q2-Q4	Local benchmark			Target for year was less than 1,065; actual for year was 1,027
Patient cancelled on the day of surgery for non-clinical reasons who does not meet the 28 day guarantee					3 (data from Oct 2013-Mar 2014)	3
Urgent operations that have been cancelled for non-clinical reasons for a second or subsequent time					5 (full year data)	3
Comment: The baseline for all hospital non-clinical cancellation was established at the end of Q1 averaging around 118 per month. In Q2 this rose to an average of 144 per month with a peak in September of 184. The increase in cancellations in Q2 was predominately due to significant recruitment issues with junior doctors reducing theatre capacity available and a higher number of urgent cases that take priority. The target for reducing cancelled cases per month for non-clinical reasons was 118 per month in Q1 and 79 per month in Q2-Q4.						

2014/15	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	74	91	71	112	76	143	112	81	63	94	66	74
Target	118	118	118	79	79	79	79	79	79	79	79	79

Performance against national targets

National priority indicators	Measure	Target	2014/15	
Clostridium difficile infections	Count	0	1	Red
MRSA bacteraemia	Count	0	0	Green
Cancer: 2 week wait from urgent GP referral to first date seen	%	93%	95%	Green
Cancer: 31 day wait from diagnosis to first treatment	%	96%	97%	Green
Cancer: 31 day wait for second or subsequent treatment - surgery	%	94%	97%	Green
Cancer: 62 day wait from urgent GP referral to treatment	%	85%	94%	Green
Cancer: 62 day wait (upgraded to urgent after referral)	%	N/A	100%	Green
Cancer screening: 62 day	%	N/A	100%	Green
Attendees completing treatments and leaving within 4 hours in minor injuries unit	%	95%	99.3%	Green
18 week referral to treatment - admitted	%	90%	88.9%	Red
18 week referral to treatment - non-admitted	%	95%	93.7%	Red
18 week referral to treatment - incomplete pathways	%	92%	93.5%	Green
Receving diagnostic test within 6 weeks	%	99%	99.4%	Green
Cancellations on the day of operation and not rebooked within 28 days	Count	N/A	0	Green

Statements from third parties

Statement from Healthwatch West Sussex

Healthwatch West Sussex welcomes the improvement in engagement with the trust on significant issues such as PLACE audits this year and the quality accounts prioritisation and criteria selection process (although the latter requires further refinement). The feedback process established with the attendance of our liaison representative at the trust's patient engagement meetings has been a positive development and we look forward to seeing recordable outcomes as a result of our enhanced involvement. We are pleased to see that the views and concerns of patients in respect of food quality are recognised as one of the three priorities for improvement for the trust over 2015/16. Otherwise the commendable patient experience indicators are noted, although we are disappointed not to see discussion of PALS and complaints data as potential learning points for the trust as standard items within the draft.

The trust would benefit from reviewing the account to clarify some areas to ensure the public can understand the dialogue. Specifically the trust's aims (page 34, penultimate bullet point; page 35, first and second bullet points and the last paragraph in the left-hand column; page 37, second and third paragraphs).

Healthwatch West Sussex looks forward to greater visibility of its literature around the trust site next year and sustained progress in its engagement with trust processes for the benefit of the patient.

Statement from West Sussex Health & Adult Social Care Select Committee

Thank you for offering the West Sussex Health & Adult Social Care Select Committee (HASC) the opportunity to comment on QVH's quality account for 2014/15.

Your quality account for 2014/15 provides thorough and clear information on the quality and performance of services. You are to be commended for the high rating QVH has achieved in both patient and staff surveys, and the fact that the Care Quality Commission gave QVH the highest rating in its overall assessment without the need for any enforcement action.

HASC is pleased to learn that good progress has been made towards the three main aims of the trust, especially the increase in the number of day cases (up by 88%) and that theatre capacity has been increased, reducing the number of out of hours operations and hastening treatment time.

HASC is aware that the trust has a strict policy of reporting all incidents that affect patient safety, and that one 'never' events occurred in the period which required reporting to Monitor. HASC welcomes the new safeguards that have been put in place to prevent this recurring.

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

Thank you for giving the Crawley, Horsham and Mid Sussex Clinical Commissioning Groups the opportunity to review and comment on your quality account 2014/15. We are in agreement that the document meets the Department of Health national guidance on quality account reporting and that as far as we can ascertain the information provided is accurate and complies with information that you have provided to the CCGs in the year and to the nationally published data available. The data presentation by use of RAG rating is helpful and provides a good visual picture of progress against last year's objectives.

Performance against 2014/15 priorities

As a specialist trust it is important to go beyond the usual regulator requirements, and in recognition the organisation would appear to have set some realistic standards for improvement. Additionally the consultant clinical outcomes work will provide patients with further information and assurance, and is a timely initiative in preparation for the national work underway.

The CCGs commend the trust on achievement of last year's objectives and are pleased to note that areas where improvement is needed are highlighted and appropriate mitigating actions taken. The implementation of the safe care module pilot aimed at facilitating safe staffing is welcomed for maintaining continuity and consistency of care provision. We welcome the FFT results with 99% of the patients recommending QVH as a place to receive care.

QVH has maintained a transparent reporting culture where serious incidents occur during care. The established staff feedback mechanisms following reported incidents are important for learning and sharing lessons learned. It would therefore be helpful to see how the trust is engaging not only with the nursing but also the medical personnel as well.

Although all 2014/15 priorities were not achieved it is helpful to know that they will continue to be monitored and acted upon through normal trust governance processes.

Priorities for 2015/16

The priorities for 2015/16 appear appropriate and reflect the need to address areas needing more accelerated improvement. These priorities are influenced by feedback from patients and other stakeholders.

The scheduling of elective surgery as a priority is welcomed. However, the CCGs have remained concerned about failure to comply with the WHO checklist and patient consent prior to the day of elective surgery. The never events reported as occurring during care provided on off-site locations is also disappointing and therefore it would be helpful to include plans on how the governance process will be monitored in these areas.

The trust had a Manchester Patient Safety Framework (MaPSaf) CQUIN agreed for 2014/15 to assist the organisation to reflect on their progress in developing a safety culture, through a programme of workshop discussions about the strengths and weaknesses of the culture in teams and/or organisations. It would therefore be helpful to share what the outcomes of this pilot were, and if there is scope to continue with the roll out in 2015/16. The priorities also lack assurance as to how workforce will be managed, supported and engaged.

It is disappointing to note that the prevalence of pressure damage has increased in the last two years which is noted as relating to prolonged surgery. The CCG will continue to support engagement with the Sussex patient safety collaborative to identify further preventative measures, and look forward to the outcomes of these in the next year.

Conclusion

The trust has made good progress with its priorities and has been deemed above average in several categories. The trust however continues to experience several challenges as common to all healthcare organisations especially in relation to workforce recruitment and retention and will be challenged in the year ahead to further improve quality whilst maintaining financial stability.

The priorities for 2015/16 appear realistic in this respect and show that the trust is taking account of patient feedback whilst planning ahead for better managed services and care pathways.

The CCGs look forward to regular updates on progress through the usual quality reviews which take place regularly throughout the year.

Statement from QVH Council of Governors

The council of governors takes a close interest in patients' experience of QVH as part of its statutory responsibility to represent the interest of members and the public.

The council aims to take account of a wide range of information and feedback in order to understand how patients and visitors experience the hospital and its services delivered at other sites across our region. These include feedback on Patient Opinion and NHS Choices websites and results and feedback from the friends and family tests, national surveys and local 'compliance in practice' assessments. Governors regularly form part of the compliance in practice assessment teams and gain valuable insight into patient experience by talking to them and their families directly. The council also nominates governor representatives who take part in all of the trust's senior and relevant governance systems that take account of patient experience and care quality.During 2014/15 governors have welcomed the feedback gained from all sources and the opportunities we have to shape and challenge the trust's performance. The council has noted the consistently high scores achieved by the trust, the gratitude of patients and compliments they have paid to their carers. Governors have also paid particular attention to less favourable feedback, lower scores and patient complaints.

So governors are pleased to note that these quality accounts reflect our understanding of patient experience in 2014/15. We believe that the accounts provide an accurate and balanced evaluation of achievement and an open and honest assessment of necessary improvements.

We very much welcome the quality priorities established for 2015/16 and will continue to hold the non-executive directors to account for the performance of the board to achieve these important objectives for the benefit of patients.

Statement of director responsibilities in respect of the quality report

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

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

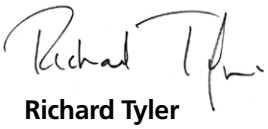
In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2013-14* and *Detailed requirements for quality reports 2014/15*;
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2014 - May 2015
  - papers relating to quality reported to the board over the period April 2014 - May 2015
  - feedback from commissioners dated 26 May 2015
  - feedback from governors dated 25 May 2015
  - feedback from Healthwatch West Sussex dated 11 May 2015
  - feedback from the Health and Adult Social Care Select Committee dated 22 May 2015
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2015
  - QVH national inpatient survey results, April 2015
  - QVH national staff survey results, February 2015
  - the head of internal audit's annual opinion over the trust's control environment dated 30 April 2015
  - CQC quality and risk profiles (now hospital intelligent monitoring report) dated December 2014
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the quality report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm they are working effectively in practice;
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions and is subject to appropriate scrutiny and review; and
- the quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report (both available at www.monitor-nhsft.gov.uk/annualreportingmanual).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board,

Beryl Hobson
Chair
28 May 2015



Richard Tyler
Chief Executive
28 May 2015

Independent auditor's report to the council of governors

We have been engaged by the council of governors of Queen Victoria Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Queen Victoria Hospital NHS Foundation Trust's quality report for the year ended 31 March 2015 (the 'quality report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the following two national priority indicators:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways ("referral to treatment – incomplete pathways"); and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers ("62 day cancer waits").

We identified weaknesses in the design of the control environment in regard to the "referral to treatment – incomplete pathways" indicator. As a result of our testing of this indicator we also identified data errors, where classification of data was miscalculated, and we were unable to gain assurance over completeness of data reported. As a result we are not able to issue a limited assurance opinion in respect of the "referral to treatment – incomplete pathways" indicator.

We identified weaknesses in the design of the control environment in regard to the "62 day cancer waits" indicator. As a result of our testing of this indicator we also identified data errors, where data included within the indicator was misclassified, and we were unable to gain assurance over completeness of data reported. As a result we are not able to issue a limited assurance opinion in respect of the"62 day cancer waits" indicator.

Respective responsibilities of the directors and auditors

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

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

- the quality report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the quality report is not consistent in all material respects with the sources specified in the *Detailed Guidance for External Assurance on Quality Reports 2014/15* ('the guidance'); and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the guidance.

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

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

- board minutes for the period April 2014 to May 2015;
- papers relating to quality reported to the board over the period April 2014 to May 2015;
- feedback from the commissioners dated May 2015;
- feedback from local Healthwatch organisations dated May 2015;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2014/15;
- the 2014/15 national patient survey;
- the 2014/15 national staff survey;
- Care Quality Commission quality and risk profiles/intelligent monitoring reports 2014/15; and
- the 2014/15 head of internal audit's annual opinion over the trust's control environment.

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

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

This report, including the conclusion, has been prepared solely for the council of governors of Queen Victoria Hospital NHS Foundation Trust as a body, to assist the council of governors in reporting the NHS foundation trust's quality agenda, performance and activities. We permit the disclosure of this report within the annual report for the year ended 31 March 2015, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we

do not accept or assume responsibility to anyone other than the council of governors as a body and Queen Victoria Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

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

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

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

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

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- the quality report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*; and
- the quality report is not consistent in all material respects with the sources specified in the guidance.

KPMG LLP
Chartered Accountants
15 Canada Square
London
E14 5GL
28 May 2015

7

Staff survey

7.1 Statement of approach to staff engagement

QVH recognises that its staff and the high standards of care they provide are the crucial factors in its continuing success and excellent patient feedback. The trust believes in providing staff with opportunities to contribute to the development of the hospital and the services it provides and organises monthly staff briefings, walk-rounds by members of the executive team, a fortnightly internal staff newsletter and access to an intranet site.

As part of its approach to staff engagement, QVH has improved staff involvement in decision-making through a number of initiatives including 'back to the floor' and compliance in practice sessions, both of which involve senior managers, non-executive directors and governors working alongside frontline staff, engaging with them and patients. Staff were also engaged in 2014/15 in a major management re-structure that aligned services with surgical specialties and had opportunities to influence the final structure.

Formal consultation with staff continues to be driven through:

- Joint consultation and negotiation committee – involving trade union and management representatives
- Local negotiating committee – involving managers and medical staff representatives and including a British Medical Association representative.

The trust's working relationships with staff-side representatives is very constructive and they have supported the trust throughout the year with the changes to the management structure and national industrial disputes. Their positive approach to working alongside management has been instrumental in enabling QVH to maintain the highest quality of care whilst promoting the interests of staff.

The *QVH 2020* organisational strategy introduced during 2014/15 has been closely aligned with the trust's values of continuous improvement, humanity and pride. Additionally, the trust has embedded values based recruitment to ensure it employs staff who demonstrate empathy and compassion in line with the NHS Constitution.

Whilst a number of initiatives have been implemented throughout the year, they will require time to become embedded into the culture of the organisation and therefore the impact will not be evident until the 2015 staff survey and beyond.

7.2 Results from the NHS staff survey

The national decline in this year's NHS staff survey results was evident to some extent in the QVH results with a slight drop in the overall staff engagement score from 4.01 (out of 5) to 3.94. However, QVH's score is in line with the average for specialist acute trusts and the score for staff recommendation of the trust as a place to work or be treated remains well above the national average. On many of the other measures, QVH continues to be among the top performing trusts.

The survey provides 28 key findings based around four of the seven pledges to staff in the NHS Constitution. In addition it assesses two other themes: the extent to which staff would recommend the trust as a place to work or receive treatment and how this affects motivation; and how well the trust performs as a fair employer, particularly in relation to equality and diversity.

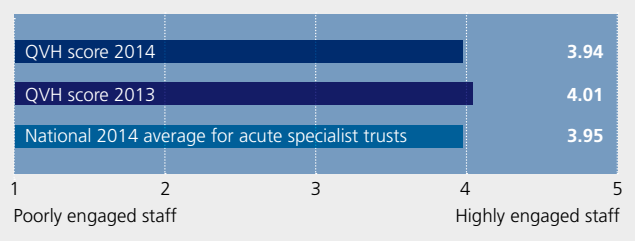
The trust's performance on some of these key factors is set out in the table and chart below.

Key finding / question	Description	QVH performance 2014	Average (median) for acute specialist trusts (2014)	QVH performance 2013
KF 24 / Q12a	Care of patients / service users is my organisation's top priority	84%	84%	88%
KF24 / Q12b	My organisation acts on concerns raised by patients / service users	85%	83%	87%
KF24 / Q12c	I would recommend my organisation as a place to work	74%	73%	81%
KF24 / Q12d	If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	91%	81%	94%
KF 24 overall	Staff recommendation of the trust as a place to work or receive treatment	4.18*	4.14*	4.26*

* Based on a 1 to 5 rating with 1 the lowest performance and 5 the highest.

Overall staff engagement

The staff survey results are used by the trust to assess the impact of changes and improvements to staff engagement and the working environment and to identify priorities for further work, in line with the trust's value of continuous improvement. The top and bottom ranking scores from the survey are set out in the tables below.



	2013		2014		
Top 5 ranking scores	**QVH**	**National average**	**QVH**	**National average**	**QVH improvement/ deterioration**
KF19: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	22%	22%	19%	23%	3% improvement
KF15: Percentage of staff agreeing that they would feel secure raising concerns about unsafe practice	N/A	N/A	75%	70%	New measure for 2014
KF13: Percentage of staff reporting errors, near misses or incidents witnessed in the last month	93%	90%	94%	92%	1% improvement
KF24: Staff recommendation of the trust as a place to work or receive treatment	4.26	3.71	4.18	4.14	0.08 deterioration
KF17: Percentage of staff experiencing physical violence from staff in the last 12 months	1%	2%	1%	1%	No change

	2013		2014		
Bottom 5 ranking scores	**QVH**	**National average**	**QVH**	**National average**	**QVH improvement/ deterioration**
KF7: Percentage of staff appraised in the last 12 months	81%	85%	78%	84%	3% deterioration
KF4: Effective team working	3.86	3.80	3.77	3.83	0.09 deterioration
KF8: Percentage of staff having well-structured appraisals in last 12 months	41%	42%	37%	42%	4% deterioration
KF9: Support from immediate managers	3.74	3.72	3.74	3.78	No change
KF3: Work pressure felt by staff	2.85	2.88	2.93	2.91	0.08 deterioration

QVH is conducting a detailed review of staff survey results over the last three years to develop an improvement action plan. Progress against the plan will be reported regularly to the trust board and council of governors. A number of immediate priorities have already been identified for the coming year, including:

- appraisals and their effectiveness
- improvements in team working
- health and safety training
- managing work related stress.

Health and safety training is a priority due to the impact of the changes to the mandatory training cycle. It should be noted that since the staff survey was carried out in October 2014, sickness related stress has dropped significantly. However, the reduction of any work related stress remains a key priority.

Occupational health services have been improved to help staff when they are unwell and QVH has seen a drop in reported sickness from a national average of around 4% in 2013 to 2.85% in 2014. Further enhancements are planned.

Work has already begun on improving the trust's approach to appraisals with a new system introduced in January 2014.

8

Regulatory ratings

The trust made a surplus of £2,261K for the year. This represents a strong performance given the cost pressures the trust faced and is reflected in the ratings shown below.

The trust reports its performance to Monitor, the sector regulator for health services in England, on a quarterly basis. This includes both financial and operational performance and these are summarised into two risk ratings. In October 2013, Monitor changed the way in which these risk ratings are calculated and replaced the financial risk rating (scale 1 (high risk) to 5 (low risk)) with the continuity of services risk rating (scale 1 (high risk) to 4 (low risk)).

QVH's cumulative 2014/15 ratings are summarised below.

	Q1	Q2	Q3	Q4
Continuity of services risk rating	4	4	4	4
Governance risk rating	Green	Green	Green	Green

During the first part of 2014/15, QVH experienced difficulties in consistently achieving the 18 week referral to treatment target for admitted, non-admitted and open patients, both at service line and corporate level. Demand for services remained high, including tertiary referrals from other hospitals, which resulted in waiting lists growing in some services. This meant it was not always possible to treat patients as promptly as the trust should have.

Between June and November 2014, the trust focused on tackling its waiting times to achieve a sustainable 18 week position for all patients in all specialties. This involved undertaking a review of its scheduling processes, increasing theatre capacity and clinics as well as improving the information available to the operational teams. This coincided with a national drive to reduce waiting times.

Thanks to the efforts of its staff, since December 2014 QVH has achieved all three 18 week performance standards consistently at a trust level and in almost all specialties. Plans are being implemented to ensure that this is sustained for 2015/16.

The trust has achieved almost all of the cancer targets for 2014/15 with the exception of 31 days patients in Q1 and 62 days patients in Q2. These were predominately patients who had been referred to us for treatment as a tertiary centre, which meant that in some cases, due to complex care pathways or the need for visiting surgeons, they waited longer than they should have. QVH has been working closely with all other providers in the region to ensure that patients' waiting times for cancer treatment are continually improved and for the last two quarters of the year the trust has achieved all of the cancer waiting time targets.

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

QVH is registered with the Care Quality Commission (CQC) and is licensed to deliver specified services at one location; the QVH site.

There are no quality concerns from Monitor or the CQC for 2014/15. Monitor rate QVH as green for quality and the CQC intelligent monitoring system rates QVH at 6 (which is the lowest risk) for priority inspection.

9

Other disclosures in the public interest

Other disclosures in the public interest

Actions taken by the NHS foundation trust to maintain or develop the provision of information to, and consultation with, employees

See section 3.1 above.

The NHS foundation trust's policies in relation to disabled employees and equal opportunities

See section 3.1 above.

Information on health and safety performance and occupational health

The trust provides a comprehensive occupational health services to its employees. Key issues addressed during 2014/15 have included:

- Supporting staff and managers in the effective management of sickness absence
- Providing training and advice on moving and handling
- Reviewing and improving the service for staff with the introduction of a 24/7 helpline for needle stick injuries
- Reviewing and updating relevant policies in support of the trust's health and safety leads.

Information on policies and procedures with respect to countering fraud and corruption

See section 5.2, row 73 above.

A statement describing the better payment practice code, or any other policy adopted on payment of suppliers, and performance achieved, together with disclosure of any interest paid under the Late Payment of Commercial Debts (Interest) Act 1998

The better payment practice code requires the trust to aim to pay all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

	2013/14		2014/15	
	Number	Value £000	Number	Value £000
Total bills paid in year	13,407	17,956	16,875	21,902
Total bills paid within target	9,731	14,983	11,311	14,349
Percentage of bills paid within the target	**73%**	**83%**	**67%**	**66%**

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

Details of any consultations completed in the previous year, consultations in progress at the date of the report, or consultations planned for the coming year

Not applicable.

Consultation with local groups and organisations, including overview and scrutiny committees of local authorities covering the membership areas

Not applicable.

Any other public and patient involvement activities

None to disclose.

10

Annual governance statement

10.1 Scope of responsibility

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

10.2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the 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 2015 and up to the date of approval of the annual report and accounts.

10.3 Capacity to handle risk

Risk management is a corporate responsibility and, accordingly, the board of directors has ultimate responsibility for ensuring that effective processes are in place. The board is committed to the continuous development of a framework to manage risks in a structured and focused way in order to prevent harm to its patients, staff, public and other stakeholders and to protect the trust from losses or damage to its reputation.

The director of nursing and quality is the trust's lead for risk, supported by the head of risk. The trust's quality and risk committee oversees the management of all areas of risk in the organisation. It is chaired by a non-executive director and is attended regularly by directors and senior managers. Reporting lines to the board for quality and risk are through this committee.

The trust's risk management and incident reporting policy is available for all staff and provides clear procedures for identifying, reporting, investigating, managing and monitoring incidents and risks. Staff are trained or equipped to manage risk in a way appropriate to their authority and duties. The trust is committed to supporting its staff in exercising their roles and responsibilities with regard to health and safety and all other forms of risk management. Basic risk training is mandatory for all new staff to the trust and updates are delivered as part of the training programme. Department managers receive more in-depth risk training and the trust's board members also receive an annual update. The trust has a risk team in place to provide support to staff and ensure effective risk processes are in place.

Systems are in place through effective risk management software, the risk team and organisational structures such as directorates and monitoring committees to manage risks and incidents and to ensure learning as a result of identified issues takes place.

10.4 The risk and control framework

The trust's risk strategy provides an outline of the risk processes such as the source of risks and clear escalation processes. This strategy is supported by the risk management and incident reporting policy. The trust risk assessment tool includes a 5 x 5 matrix to determine the level of risk based on likelihood x consequence and ensures hazards, existing controls and further controls required can be clearly identified and documented. Identification of risk is achieved through the directorates and departments, supported by the risk team, and can be from a variety of sources such as incidents, audits, external compliance, inspections and service reviews. There is a five-step process in place for a risk assessment:

- Look for the hazards
- Decide who / what might be affected and how
- Evaluate the risks and decide whether existing precautions (controls) are adequate or more should be done (actions)
- Record and communicate the findings
- Review.

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

Identified risks are classed as departmental or corporate. Departmental risks are low-level risks managed within departments to ensure staff are aware of potential hazards within their working practice. Corporate risks may be from escalated departmental concerns or are risks affecting the whole trust requiring input and monitoring from directorates and senior committees. The trust risk appetite is based on the level of risk and the authority a manager or committee has in managing it. High-level risks (major and catastrophic rated 16-25) will be escalated to directorate level and reviewed by the directorates, quality and risk committee and trust board.

If adequate controls cannot be put in place to treat the risk a decision will be made to terminate, transfer or accept the risk.

All risks rated 12 and above are escalated to the trust board and reviewed on a monthly basis. Where applicable actions to reduce each risk are assigned to an individual and monitored for progress by the relevant committee. The quality and risk committee reviews and monitors all corporate risks to ensure reduction of risks is taking place wherever possible. The risk team provides support to all departments and monitors the risks in terms of review dates, determined levels (risk rating) and progress, and highlights concerns to committees and individuals. Each risk is categorised in the system under one of the following headings:

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

Each risk on the register is linked to one of the five key strategic objectives to ensure the organisation can see the risks that could prevent achievement of the objective.

In addition to the risk register the trust has a board assurance framework in place designed to map the key risks and priorities identified in the annual plan that could prevent the organisation meeting its key strategic objectives. The assurance framework comprises the following elements:

- Risk source and description – high-rated risks from the risk register or priorities within the annual plan with the potential to prevent the trust achieving its five key strategic objectives.
- Key controls – controls currently in place to mitigate against the risks identified. Any gaps in control are identified as actions and listed within the framework for monitoring progress.
- Sources of assurance – these are the sources of assurance currently available for each area of risk. Any gaps in assurance are also identified.
- Current and residual rating – risk rating for each risk source based on the assessment of likelihood x consequence, taking into account the controls in place.

Each risk source is allocated an executive lead to ensure appropriate controls and sources of assurance are in place. Gaps in either of these result in the development of an action plan recorded within the assurance framework. The risk team updates progress with each executive lead and the document is reviewed and monitored by the quality and risk committee, audit committee and trust board.

Risk management is included within each directorate meeting agenda and existing risks are discussed along with the identification of new risks. Learning from incidents is integral to the risk process and the trust therefore has an incident reporting system in place along with a process to investigate, review and learn from events. The clinical policy committee monitors the higher rated incidents to ensure correct action and learning has taken place. The quality and risk committee receives a full report on a quarterly basis covering qualitative and quantitative data on incidents, complaints, claims and patient experience. In addition, the trust board receives a monthly quality and risk report providing information on risks, incidents and quality.

Public stakeholders are also involved in managing risks through the risks identified by external assessors, incidents, complaints and other external bodies. In addition, a public governor attends meetings of the quality and risk committee.

In respect of maintaining the requirements of registration with the CQC and to prepare for our CQC inspection a detailed self- assessment tool has been designed for all ward and team leads at QVH to review their services and standards of care. This information has been collated to provide insight into our compliance with the CQC's regulatory model that will judge whether the trust's services and care provision are safe, effective, responsive, caring and well-led. Specialties will be rated against the core CQC inspection frameworks for acute hospitals to ensure focus on key areas. The director of nursing is the executive lead and will ensure processes are in place to provide management and board assurance. The risk team monitors the process and any potential weakness is addressed and assigned to an individual as an action. The quality and risk committee reviews outstanding actions and the CQC quality and risk profile on a quarterly basis to ensure processes are in place to address areas of reduced compliance.

The board also gets its assurances from the internal auditors, external auditors, independent review bodies and audit committee, which has reviewed the trust's management of risk through the quality and risk committee. The board follows the principles of the Monitor quality governance framework in assessing the level of quality governance within the trust, determining the assurances required and designing the audit work programme.

QVH uses the board's quality and risk sub-committee as a key source of assurance in respect of quality, but other bodies play an important part in measuring, monitoring and managing quality around the trust. The board receives a detailed exception report in respect of quality indicators at each meeting. The areas covered in the report focus on patient experience, patient safety and clinical effectiveness and help the board to assess levels of assurance available to demonstrate that the trust is safe, caring, effective, responsive and well led.

The trust initiated a review of its existing governance arrangements during 2014/15. The aim of the review, which is being led by the trust chair, is to ensure that governance arrangements remain fit for purpose and are compliant with the requirements of the well-led domain within the CQC inspection regime.

The foundation trust is fully compliant with the CQC registration requirements.

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 the organisation complies with all its obligations under equality, diversity and human rights legislation.

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

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

QVH has a strong track record of financial performance with robust processes in place to ensure the economic, efficient and effective use of resources.

The trust has a detailed business planning process that involves comprehensive meetings with the clinical directorates to determine the business plans for the coming year. For 2014/15 the emphasis remained on the planning of clinical activity and the establishment of the activity plans for the next three years. The process further enhanced the clinical input to planning at service line level.

QVH has strong financial management arrangements in place with a comprehensive finance and performance report presented to the board on a monthly basis which includes key performance indicators for productivity and efficiency gains. Detailed activity and performance information is produced monthly for clinical service lines to inform management planning and decision making.

During the year, QVH continued to develop its service line reporting by ensuring the flow of patients through clinical services and the level of demand for services was assessed alongside financial performance. A number of the key corporate objectives for clinical directorates have been based on the outcomes of service line reporting and specific action plans have been introduced where performance was below plan.

QVH continues to undertake value added reviews which are reported to the audit committee.

QVH has reviewed its use of natural resources and has developed a strategy to reduce its carbon footprint. This strategy includes a sustainable development management action plan, a commitment to sign up to best practice models, close monitoring of carbon usage and to promote awareness within the organisation.

10.6 Information governance

The trust's overall score for information governance assessment in 2014/15 was 82% and was graded green (satisfactory).

All staff and volunteers are mandated to undertake information governance training on at least an annual basis to assist in awareness of their responsibilities for safeguarding confidentiality, protecting data and preserving information security.

The trust did not report any significant personal data breaches in 2014/15. Four incidents were categorised as serious incidents as per the national framework. They were fully investigated and graded at a minor level. No patient harm resulted from any of the incidents which were:

- A patient letter detailing an outpatient appointment outcome was accidentally photocopied on to the back of another patient letter
- Two patients' microbiology results were sent to the wrong patient addresses
- Updated patient details were not processed in a timely manner resulting in an appointment letter being sent to the patient's previous address
- A patient label was accidentally affixed to a different patient's outcome form.

10.7 Annual quality report

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

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

- Quarterly updates to the quality and risk committee on progress against priorities identified in the 2014/15 quality accounts.
- Monthly updates to clinical cabinet and the board of directors on metrics (including MRSA, cancer 62 days and 18 weeks referral to treatment targets).

- The clinical outcomes group receiving specialty information, audit and national audit outcome data.
- External audit of systems and processes for data collection.

10.8 Review of effectiveness

As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and the quality and risk committee. 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 assurance framework and risk registers, as well as minutes from audit committee and quality and risk committee meetings. Key risks are fully debated and the board ensures actions are in place where necessary.
- The board receives monthly reports on financial and quality performance.
- The board receives regular information governance reports.
- The audit committee reviews findings from internal and external audit work and ensures links to the risk register and assurance framework are maintained.
- The head of internal audit opinion has given a 'significant assurance' rating on the effectiveness of the systems of internal control.
- The quality and risk committee reviews feedback from external assessments on quality of service, including CQC, NHSLA and audit, as well as ensuring internal quality measures are regularly tested and standards are met.

10.9 RTT18

The trust acknowledges that QVH patients whose entire patient pathway is delivered at Medway Maritime Hospital are not recorded within the QVH indicator. If patients begin their pathway of treatment at Medway and continue at QVH, they are included.

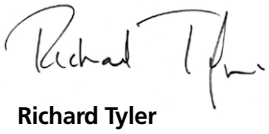
For patients whose entire pathway of care is delivered at Medway, it is imperative that they are reported on as part of the QVH indicator. Numerous attempts have been made to access this data from Medway without success. This has been compounded by a recent change to the Medway patient administration system (PAS).

In future, the trust will seek weekly rather than monthly access to this data at a patient level rather than summary level. This will enable the trust to construct a patient tracking list for off-site patients as for on-site patients. The trust will also:

- Establish whether Medway can meet these requirements and then manage them with a robust service level agreement.
- Put in place a tracking and validation process for Medway patients to mirror its process for on-site patients.
- Develop longer-term feasibility plan for the trust's own PAS be installed at its off-site locations.

10.10 Conclusion

The trust has continued to face significant challenges in 2014/15 and, despite on-going pressures, has continued to achieve good operational and financial performance in the year. The review of governance and controls confirms that the trust has managed risks effectively through the year and can provide assurance that effective systems are in place to support the running of the organisation. I am pleased to conclude that at the end of the year there are no significant internal control issues for the trust.



Richard Tyler
Chief Executive
28 May 2015

11

Financial accounts

11.1 Statement of accounting officer's responsibilities

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

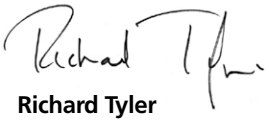
Under the NHS Act 2006, Monitor has directed Queen Victoria Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the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

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

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

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

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



Richard Tyler
Chief Executive
21 May 2015

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

Opinions and conclusions arising from our audit

1 Our opinion on the financial statements is unmodified

We have audited the financial statements of Queen Victoria Hospital NHS Foundation Trust for the year ended 31 March 2015 set out on pages pages 80 to 106. In our opinion:

- the financial statements give a true and fair view of the state of the group's and the trust's affairs as at 31 March 2015 and of the group's and the trust's income and expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15.

2 Our assessment of risks of material misstatement

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

NHS income recognition - £57 million

The risk: The main source of income for the group is the provision of healthcare services to the public under contracts with NHS commissioners, which make up (99%) of income from activities. The group participates in the agreement of balances (AoB) exercise which is mandated by the Department of Health (the Department), covering the English NHS only, for the purpose of ensuring that intra-NHS balances are eliminated on the consolidation of the Department's resource account. The AoB exercise identifies mismatches between receivable and payable balances recognised by the group and its counter parties at the balance sheet date.

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

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

Our response: In this area our audit procedures included:

- Agreeing the income recorded in the group's financial statements to the signed contracts in place with key counter parties, and investigating significant contract variations supported by explanations provided by trust officers;
- Assessing third party confirmations from NHS bodies as part of the 2014/15 agreement of balances exercise and obtaining explanations for any significant variances; and
- Testing a sample of income items from year end bank statements to support the work we have undertaken on completeness of income balances recorded in the financial statements and confirming that income has been recorded in the correct accounting period.

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

The materiality for the financial statements was set at £1.2M, determined with reference to a benchmark of income from operations (of which it represents 2%). We consider income from operations to be more stable than a surplus-related benchmark.

We report to the audit committee any corrected and uncorrected identified misstatements exceeding £61K, in addition to other identified misstatements that warrant reporting on qualitative grounds.

The group has two reporting components (the trust and the charitable fund) and both are subject to audit for group reporting purposes performed by the group audit team at one location in the for the year and total assets. The audits performed for group reporting purposes are performed to headquarters of the trust in East Grinstead. The audits cover 100% of group income, financial outturn materiality levels ranging from £1.2M to £21K.

4 Our opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts is unmodified

In our opinion:

- the part of the directors' remuneration report to be audited has been properly prepared in accordance with the *NHS Foundation Trust Annual Reporting Manual 2014/15*; and
- the information given in the strategic report and the directors' report for the financial year for which the financial statements are prepared is consistent with the financial statements.

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

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

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

- We have identified material inconsistencies between the knowledge we acquired during our audit and the directors' statement that they consider that the annual report and accounts taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the group's performance, business model and strategy; or

- the audit committee's commentary included in section 5 of the annual report does not appropriately address matters communicated by us to the audit committee.

Under the Audit Code for NHS Foundation Trusts we are required to report to you if in our opinion:

- The annual governance statement does not reflect the disclosure requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2014/15*, is misleading or is not consistent with our knowledge of the group and other information of which we are aware from our audit of the financial statements.

- The trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

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

Certificate of audit completion

We certify that we have completed the audit of the accounts of Queen Victoria Hospital NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Our certificate is qualified in accordance with paragraph 5.12 of the audit code as whilst we have issued a limited assurance opinion in relation to the content of the quality report, we have not issued an opinion in relation to the trust's other mandated indicators (18 week referral to treatment target and 62 day cancer waits).

Respective responsibilities of the accounting officer and auditor

As described more fully in the statement of accounting officer's responsibilities on page 76 the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the UK Ethical Standards for Auditors.

Scope of an audit of financial statements performed in accordance with International Standards on Auditing (UK and Ireland)

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

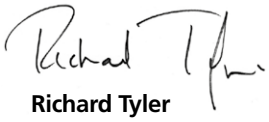
The purpose of our audit work and to whom we owe our responsibilities

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

KPMG LLP
Chartered Accountants
15 Canada Square
London
E14 5GL
28 May 2015

11.3 Foreword to the accounts

These accounts for the year ended 31 March 2015 have been prepared by Queen Victoria Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.



Richard Tyler
Chief Executive
21 May 2015

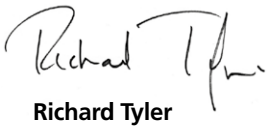
11.4 Statement of comprehensive income

STATEMENT OF COMPREHENSIVE INCOME FOR THE PERIOD ENDED 31 MARCH 2015							
	Notes		**2014/15 Group £000**		**2014/15 Trust £000**	2013/14 Group £000	2013/14 Trust £000
Operating income	3,4		**62,866**		**62,943**	62,394	62,337
Operating expenses	5		**(59,613)**		**(59,547)**	(61,351)	(61,192)
Operating surplus/(deficit)			**3,253**		**3,396**	1,043	1,145
Finance costs							
Finance income	10	21		18		25	20
Finance expense – unwinding of discount on provisions	19	(8)		(8)		(9)	(9)
Finance expense – other	20	(261)		(261)		(263)	(263)
PDC dividends payable		(884)		(884)		(832)	(832)
Net finance costs			**(1,132)**		**(1,135)**	(1,079)	(1,084)
SURPLUS/(DEFICIT) FOR THE YEAR			**2,121**		**2,261**	(36)	61
Other comprehensive income: (See statement of changes in taxpayers' equity on page 82)							
Revaluation gains/(losses) on property, plant and equipment			-		**-**	1,442	1,442
Impairment through revaluation reserve			-		**-**	(692)	(692)
Other recognised losses			-		**-**	(14)	(14)
INCOME/(EXPENSE) FOR THE PERIOD			**2,121**		**2,261**	700	797

11.5 Statement of financial position

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2015					
	Notes	**31 March 2015 Group £000**	**31 March 2015 Trust £000**	31 March 2014 Group £000	31 March 2014 Trust £000
NON-CURRENT ASSETS					
Intangible assets	11	**975**	**975**	718	718
Property, plant and equipment	12	**36,730**	**36,730**	36,493	36,493
Total non-current assets		**37,705**	**37,705**	37,211	37,211
CURRENT ASSETS					
Inventories	14	**440**	**440**	415	415
Trade and other receivables	15	**8,351**	**8,351**	8,939	8,939
Cash and cash equivalents	16	**7,446**	**6,548**	4,693	3,655
Total current assets		**16,237**	**15,339**	14,047	13,009
CURRENT LIABILITIES					
Trade and other payables	17	**(6,333)**	**(6,327)**	(4,502)	(4,496)
Borrowings	21.1	**(778)**	**(778)**	(778)	(778)
Provisions	19	**(339)**	**(339)**	(1,108)	(1,108)
Other liabilities	18	**(436)**	**(436)**	(192)	(192)
Total current liabilities		**(7,886)**	**(7,880)**	(6,580)	(6,574)
NON-CURRENT LIABILITIES					
Provisions	19	**(588)**	**(588)**	(554)	(554)
Long term borrowings	21.1	**(8,156)**	**(8,156)**	(8,933)	(8,933)
Total non-current liabilities		**(8,744)**	**(8,744)**	(9,487)	(9,487)
Total assets employed		**37,312**	**36,420**	35,191	34,159
TAXPAYERS' EQUITY (See statement of changes in taxpayers' equity on page 82)					
Public dividend capital		**12,237**	**12,237**	12,237	12,237
Revaluation reserve		**5,801**	**5,801**	6,173	6,173
Income and expenditure reserve		**18,382**	**18,382**	15,749	15,749
Charitable fund reserves		892	**-**	1,032	-
Total taxpayers' equity		**37,312**	**36,420**	35,191	34,159

The accounts on pages 80 to 83 were approved by the board on 21 May 2015 and are signed on the board's behalf by:



Richard Tyler
Chief Executive
21 May 2015

The notes on pages 84 to 106 form part of these accounts.

11.6 Statement of changes in taxpayers' equity

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

2013/14	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Charitable fund reserve £000	**Total £000**
Group (restated)					
Taxpayers' equity at 31 March 2013	12,212	6,266	14,859	1,129	**34,466**
Surplus for the year	-	-	61	(97)	**(36)**
Transfers between reserves	-	1,442	-	-	**1,442**
Revaluation of property, plant and equipment	-	(692)	-	-	**(692)**
Impairments	25	-	-	-	**25**
Other reserves movements	-	(843)	829	-	**(14)**
Taxpayers' equity at 31 March 2014	12,237	6,173	15,749	1,032	**35,191**
Trust					
Taxpayers' equity at 31 March 2013	12,212	6,266	14,859	-	**33,337**
Surplus for the year	-	-	61	-	**61**
Transfers between reserves	-	1,442	-	-	**1,442**
Revaluation of property, plant and equipment	-	(692)	-	-	**(692)**
Impairments	25	-	-	-	**25**
Other reserves movements	-	(843)	829	-	**(14)**
Taxpayers' equity at 31 March 2014	12,237	6,173	15,749	-	**34,159**

11.7 Statement of cash flows

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2015							
	Notes		2014/15 Group £000		2014/15 Trust £000	2013/14 Group £000	2013/14 Trust £000
Operating surplus			**3,253**		**3,396**	1,043	1,145
Non-cash income and expense							
Depreciation and amortisation	5		**2,291**		**2,291**	2,190	2,190
Impairments	5		**-**		**-**	3,530	3,530
Reversal of impairments	4		**-**		**-**	(736)	(736)
Loss on disposal of property, plant and equipment	5		**5**		**5**	1	1
Non-cash donations credited to income	4		**(270)**		**(270)**	(213)	(213)
(Increase)/decrease in inventories	14		**(25)**		**(25)**	(25)	(25)
(Increase)/decrease in trade receivables	15		**500**		**500**	(5,270)	(5,395)
Increase/(decrease) in trade and other payables	17		**2,102**		**2,102**	255	274
Increase/(decrease) in provisions	19		**(743)**		**(743)**	1,104	1,104
Increase/(decrease) in other liabilities	18		**244**		**244**	63	63
Net cash inflow from operations			**7,357**		**7,500**	1,942	1,938
Cash flows from investing activities							
Interest received	10	**21**		**18**		25	20
Payments to acquire intangible assets	11	**(465)**		**(465)**		(291)	(291)
Payments to acquire property, plant and equipment	12	**(2,208)**		**(2,208)**		(8,424)	(8,424)
Net cash used in investing activities			**(2,652)**		**(2,655)**	(8,690)	(8,695)
Cash flows from financing activities							
Public dividend capital received		**-**		**-**		25	25
Loans from Foundation Trust Financing Facility	21.1	**-**		**-**		3,600	3,600
Loans from Independent Trust Financing Facility		**(778)**		**(778)**		(389)	(389)
Interest paid	20	**(267)**		**(267)**		(226)	(226)
PDC dividends paid		**(907)**		**(907)**		(735)	(735)
			(1,952)		**(1,952)**		
Increase in cash			**2,753**		**2,893**	(4,473)	(4,482)
Cash and cash equivalents at 1 April 2014	16		**4,693**		**3,655**	9,166	8,137
Cash and cash equivalents at 31 March 2015	16		**7,446**		**6,548**	4,693	3,655

11.8 Notes to the accounts

1 Accounting policies

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the *NHS Foundation Trust Annual Reporting Manual* which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2014/15 *NHS Foundation Trust Annual Reporting Manual* issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

1.1 Income

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

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

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

1.2 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

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

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

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

1.3 Expenditure on other goods and services

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

1.4 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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

Measurement

Valuation

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

To this end, valuations of land, buildings and fixtures are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and

Valuation Manual. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the balance sheet date. Revaluations are never less than triennial. The latest valuations were undertaken in 2014 as at the prospective valuation date of 31 March 2014 and were accounted for in the 2013/14 accounts.

Fair values are determined as follows:

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

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

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

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

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

Equipment is stated in the statement of financial position at its revalued amount, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the balance sheet date. In the intervening periods the trust considers depreciated historic cost to be a suitable estimate of fair value. In the absence of regular markets from which market values can be assessed, revaluations are based on suitable indices such as the Hospital Service Cost Index published by the Department of Health. No such valuation was carried out in 2013/14.

Subsequent expenditure

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

Depreciation

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

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

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

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

Revaluation and impairment

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

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

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

1.5 Intangible assets

Recognition

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

Internally generated intangible assets

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

Expenditure on research is not capitalised.

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

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the trust intends to complete the asset and sell or use it;
- the trust has the ability to sell or use the asset;

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

Software

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

Measurement

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

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

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

Amortisation

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

1.6 Inventories

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

1.7 Cash and cash equivalents

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

1.8 Trade receivables

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

1.9 Trade payables

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

1.10 Financial assets and financial liabilities

Recognition

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

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

De-recognition

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

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

Classification and measurement

Financial assets are categorised as 'loans and receivables'.

Financial liabilities are classified as 'financial liabilities'.

Loans and receivables

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

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

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

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

Financial liabilities

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

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

Impairment of financial assets

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

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

1.11 Leases

Finance leases

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

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

Operating leases

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

Leases of land and buildings

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

The trust as lessor

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

1.12 Provisions

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

Clinical negligence costs

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

Other NHSLA schemes

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

1.13 Contingencies

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

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

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

1.14 Public dividend capital

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

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

1.15 Value added tax

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

1.16 Corporation tax

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

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

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

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

No corporation tax was charged to the trust for the financial year ending 31 March 2015.

1.17 Foreign exchange

The functional and presentational currencies of the trust are sterling.

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

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

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

1.18 IASB standard and IFRIC interpretations

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

i) IFRS 9 - Financial Instruments
Financial Assets. Financial Liabilities. This is a new standard to replace - IAS 39 Financial Instruments: Recognition and Measurement. The main changes are in respect of financial assets where the existing four categories will be reduced to two: Amortised Cost and 'Fair Value through Profit and Loss'. Expected to be effective from 2017/18.

ii) IFRS 13 - Fair Value Measurement
This provides a single source of guidance for all fair value measurements, clarifying the definition of fair value and enhancing disclosures about reported fair value estimates. Effective date of 2013/14 but not yet adopted by HM Treasury.

iii) IFRS 15 - Revenue from contracts with customers
This specifies how and when revenue should be recognised and requires more informative disclosures. Not yet adopted by the EU. Expected to be effective from 2017/18.

iv) IAS 36 (amendment) - Recoverable Amount Disclosures
Linked to IFRS 13, the amendments relate to the measurement of the recoverable amount of impaired assets. To be adopted in 2015/16.

v) IAS 19 (amendment) - Employer Contributions To Defined Benefit Pension Schemes
This amendment provides clarification of the accounting treatment of employee contributions to defined benefit pension schemes. Effective from 2015/16 but not yet adopted by the EU.

vi) Annual Improvements 2012 and 2013
Effective from 2015/16 but not yet adopted by the EU.

vii) IFRIC 21 - Levies
This provides guidance on when to recognise a levy imposed by government. Adopted by the EU in June 2014 but not yet adopted by HM Treasury.

1.19 Critical accounting estimates and assumptions

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

Value of land and buildings £32,118,000 (2013/14 £30,428,000) - This is the most significant estimate in the accounts and is based on the professional judgement of the trust's independent valuer with extensive knowledge of the physical estate and market factors. The value does not take into account potential future changes in market value which cannot be predicted with any certainty.

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

Income for an inpatient stay can start to be recognised from the day of admission, but cannot be precisely calculated until after the patient is discharged. For patients occupying a bed at the 2014/15 financial year end, the estimated value of partially completed spells is £88,000 (2013/14 £72,000).

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

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

1.20 Operating segments

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

The trust derives its income from the provision of healthcare, chiefly in its capacity as a specialist provider of various forms of reconstructive surgery. Reconstructive surgery includes plastic surgery, burns surgery, maxillofacial surgery and corneoplastic surgery.

Reconstructive surgery is the trust's principal activity. Its other activities do not, individually, constitute 10% of revenue and have been aggregated.

The Queen Victoria Hospital NHS Trust Charitable Fund (see note 1.21 below) exists to carry out charitable activities relating to the NHS and the Queen Victoria Hospital in particular. It therefore costitutes an operating segment within the group accounts.

Total assets are not reported to the board by segment as all costs and activities relating to property, plant and equipment are managed centrally. Other balance sheet items, including current assets and current liabilities are also managed centrally and are therefore not analysed or reported by segment.

1.21 Consolidation of accounts

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

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

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

The funds of the charitable fund fall into three categories:

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

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

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

1.22 Third party assets

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

1.23 Pensions

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

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

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

A more detailed account of the NHS Pensions Scheme is given in note 9.

2. Operating segments

The chief operating decision maker is considered to be the trust board because it is the board that makes all major strategic decisions and oversees the day-to-day running of the trust. At monthly board meetings key operational decisions are reached following scrutiny of performance and resource allocation across the trust's operating segments.

The trust's principal activity is reconstructive surgery. Its other activities do not, individually, constitute 10% of revenue and have been aggregated.

The Queen Victoria Hospital NHS Trust Charitable Fund (see note 1.21) exists to carry out charitable activities relating to the NHS and the Queen Victoria Hospital in particular. It therefore costitutes an operating segment within the group accounts.

All accounting during the year is done on an IFRS basis and financial performance against budget for each segment is presented to senior management on a monthly basis.

The financial results for each segment were as follows:

Group	2014/15		2013/14	
	Income £000	**Expenditure £000**	**Income £000**	**Expenditure £000**
Reconstructive surgery	**47,650**	**36,071**	49,276	36,776
Charitable activities	**87**	**66**	57	159
All other segments	**15,129**	**7,295**	13,061	4,244
Total of reportable segments	**62,866**	**43,432**	62,394	41,179
Corporate services (see note below)		**13,890**		15,188
Depreciation and amortisation		**2,291**		2,190
Impairment of property, plant and equipment		**-**		2,794
Finance income		**(21)**		(25)
Finance expense		**269**		272
PDC dividends payable		**884**		832
Surplus/(deficit) for the year		**2121**		**(36)**

Trust	2014/15		2013/14	
	Income £000	**Expenditure £000**	**Income £000**	**Expenditure £000**
Reconstructive surgery	**47,650**	**36,071**	49,276	36,776
All other segments	**15,293**	**7,295**	13,061	4,244
Total of reportable segments	**62,943**	**43,366**	62,337	41,020
Corporate services (see note below)		**13,890**		15,188
Depreciation and amortisation		**2,291**		2,190
Impairment of property, plant and equipment		**-**		2,794
Finance income		**(18)**		(20)
Finance expense		**269**		272
PDC dividends payable		**884**		832
Surplus/(deficit) for the year		**2,261**		**61**

'Corporate services' includes all the costs of shared clinical services, the board, finance, IT, human resources, nursing management, estates and facilities.

3. Income from patient care activities

	2014/15 Group £000	2014/15 Trust £000	2013/14 Group £000	2013/14 Trust £000
Clinical commissioning groups and NHS England	**56,940**	**56,940**	55,178	55,178
Non-NHS:				
Private patients	**139**	**139**	185	185
Injury costs recovery	**269**	**269**	279	279
Other	**206**	**206**	121	121
	57,554	**57,554**	55,763	55,763

Notes

'Injury costs recovery' is income received from insurance companies for the treatment of patients who have been involved in road traffic accidents. It is subject to a provision for impairment of receivables of 18.9% to reflect expected rates of collection.

Commissioner requested services

The trust is working with its commissioners to determine the level of commissioner requested services currently provided. Within the 2014/15 financial statements management has taken the view that commissioner requested services are those which provide for the healthcare of NHS patients.

Of the total income reported above, £57,415,000, (2013/14 £55,578,000) was derived from the provision of commissioner requested services.

4. Other operating income

	2014/15 Group £000	2014/15 Trust £000	2013/14 Group £000	2013/14 Trust £000
Education and training	**1,574**	**1,574**	1,569	1,569
Charitable and other contributions to expenditure	**409**	**409**	129	213
Non-patient care services to other bodies	**1,754**	**1,754**	1,701	1,701
Reversal of impairments	**-**	**-**	736	736
Other income	**1,575**	**1,652**	2,496	2,355
	5,312	**5,389**	6,631	6,574

5. Operating expenses

	2014/15 Group £000	2014/15 Trust £000	2013/14 Group £000	2013/14 Trust £000
Services from NHS foundation trusts	**112**	**112**	141	141
Purchase of healthcare from non NHS bodies	**290**	**290**	139	139
Executive directors' costs	**687**	**687**	411	411
Non-executive directors' costs	**115**	**115**	114	114
Staff costs	**39,119**	**39,119**	37,570	37,570
Consultancy	**124**	**124**	60	60
Drugs	**1,262**	**1,262**	1,187	1,187
Supplies and services - clinical (excluding drugs)	**8,414**	**8,414**	8,883	8,883
Supplies and services - general	**616**	**616**	599	599
Establishment	**492**	**492**	725	725
Transport	**516**	**516**	376	376
Premises	**2,307**	**2,307**	1,931	1,931
Provision for impairment of receivables	**(162)**	**(162)**	307	307
Depreciation	**2,083**	**2,083**	2,024	2,024
Amortisation	**208**	**208**	166	166
Audit fees – statutory audit	**70**	**64**	58	52
– audit-related assurance services	**10**	**10**	7	7
– other assurance services	**-**	**-**	17	17
Clinical negligence	**336**	**336**	341	341
Loss on disposal of plant and equipment	**5**	**5**	1	1
Other	**3,009**	**2,949**	2,764	2,611
	59,613	**59,547**	**57,821**	57,662
Impairments of property, plant and equipment	**-**	**-**	**3,530**	3,530
	59,613	**59,547**	**61,351**	61,192

Note

External audit

The contract between the trust and its auditors provides for the latter's liability to be limited to £5,000,000.

6. Operating leases

As lessee

Operating leases relate to buildings, medical equipment and vehicles.

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

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

Payments recognised as an expense	2014/15 Group £000	2014/15 Trust £000	2013/14 Group £000	2013/14 Trust £000
Minimum lease payments	**519**	**519**	478	478

6. Operating leases (cont.)

Total future minimum lease payments	2014/15 Group £000	2014/15 Trust £000	2013/14 Group £000	2013/14 Trust £000
Payable:				
Not later than one year	**51**	**51**	496	496
Between one and five years	**983**	**983**	953	953
After five years	**-**	**-**	211	211
Total	**1,034**	**1,034**	1,660	1,660

7. Employee benefits and staff numbers

7.1 Employee benefits	2014/15 Group £000	2014/15 Trust £000	2013/14 Group £000	2013/14 Trust £000
Salaries and wages	**32,033**	**32,033**	31,140	31,140
Social security costs	**2,652**	**2,652**	2,651	2,651
Employer contributions to NHS Pension Scheme	**3,740**	**3,740**	3,704	3,704
Agency/contract staff	**1,939**	**1,939**	1,139	1,139
Employee benefits expense	**40,364**	**40,364**	38,634	38,634
Non-executive directors' benefits not included above	**115**	**115**	114	114
Total	**40,479**	**40,479**	38,748	38,748

7.2 Average number of people employed	2014/15 Group £000	2014/15 Trust £000	2013/14 Group £000	2013/14 Trust £000
Medical and dental	**126**	**126**	124	124
Administration and estates	**230**	**230**	219	219
Healthcare assistants and other support staff	**126**	**126**	122	122
Nursing, midwifery and health visiting staff	**175**	**175**	184	184
Scientific, therapeutic and technical staff	**153**	**153**	146	146
Bank and agency staff	**63**	**63**	59	59
Total	**873**	**873**	854	854

7.3 Directors' remuneration

Total remuneration paid to directors for the year ended 31 March 2015 (in their capacity as directors) totalled £802,000 (2013/14 £525,000). No other remuneration was paid to directors in their capacity as directors. There were no advances or guarantees entered into on behalf of directors by the trust. Employer contributions to the NHS Pension Scheme for executive directors for the year ended 31/03/2015 totalled £60,000 (2013/14 £62,000). The total number of directors to whom benefits are accruing under the NHS defined benefit scheme (the NHS Pension Scheme) was four.

7.4 Staff exit packages for staff leaving in 2014/15

Staff exit packages are payable when the trust terminates the employment of an employee before the normal retirement date or whenever an employee accepts voluntary redundancy in return for these benefits. During the year there were three cases in which contractual payments were made in lieu of notice. The cost of the packages paid in 2014/15 and 2013/14 fell within the following bands:

Exit package cost band	**2014/15 Group and trust**		2013/14 Group and trust	
£000	**Number of exit packages**	**Total exit packages by cost band**	Number of exit packages	Total exit packages by cost band
10–25 (Payment in lieu of notice)	**2**	**2**	1	1
25–50 (Compulsory redundancies)	**1**	**1**	-	-
Total	**3**	**3**	1	1

8. Retirements due to ill-health

During the year there were two early retirements due to ill health at a cost to the NHS pension scheme of £40,000 (2013/14, two at a cost to the NHS pension scheme of £130,000).

9. Pensions costs

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

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

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015 is based on the valuation data as 31 March 2012, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

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

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

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

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

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

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

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

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

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVCs run by the scheme's approved providers or by other free standing additional voluntary contributions (FSAVC) providers.

10. Finance revenue

	2014/15 Group £000	**2014/15 Trust £000**	2013/14 Group £000	2013/14 Trust £000
Interest revenue from bank accounts	**21**	**18**	25	20

11. Intangible assets - group and trust

Software licences	**2014/15 £000**	2013/14 £000
Gross cost at 1 April 2014	**1,109**	818
Additions	**465**	291
Disposals	**-**	-
Gross cost at 31 March 2015	**1,574**	1,109
Amortisation at 1 April 2014	**391**	225
Provided during the year	**208**	166
Amortisation at 31 March 2015	**599**	391
Net book value		
Purchased assets at 1 April 2014	**718**	593
Purchased assets at 31 March 2015	**975**	718

12. Property, plant and equipment – group and trust

12.1 Property, plant and equipment at 31 March 2015	Land £000	Buildings £000	Assets under construction £000	Plant and machinery £000	Information technology £000	Total £000
Cost or valuation at 1 April 2014	3,050	27,378	2,992	10,351	2,005	**45,776**
Additions - purchased	-	18	480	1,426	146	**2,070**
Additions - donated	-	-	-	270	-	**270**
Reclassifications	-	2,810	(3,240)	406	24	**-**
Disposals	-	**(8)**	(7)	(58)	-	**(73)**
At 31 March 2015	**3,050**	**30,198**	**225**	**12,395**	**2,175**	**48,043**
Depreciation at 1 April 2014	-	-	-	7,780	1,503	**9,283**
Provided during the year	-	**1,130**	-	779	174	**2,083**
Disposals	-	-	-	(53)	-	**(53)**
Depreciation at 31 March 2015	**-**	**1,130**	**-**	**8,506**	**1,677**	**11,313**
Net book value						
Purchased assets as at 1 April 2014	3,050	25,112	2,992	2,222	468	**33,844**
Donated assets as at 1 April 2014	-	2,266	-	349	34	**2,649**
Total at 1 April 2014	**3,050**	**27,378**	**2,992**	**2,571**	**502**	**36,493**
Purchased assets as at 31 March 2015	3,050	26,910	225	3,373	471	**34,029**
Donated assets as at 31 March 2015	-	2,158	-	516	27	**2,701**
Total at 31 March 2015	**3,050**	**29,068**	**225**	**3,889**	**498**	**36,730**

12.1 Property, plant and equipment (continued)						
2013/14 comparators	Land	Buildings	Assets under construction	Plant and machinery	Information technology	**Total**
	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2013	3,620	17,494	9,230	9,503	1,831	**41,678**
Additions – purchased	-	198	6,797	350	100	**7,445**
Additions – donated	-	-	-	178	35	**213**
Reclassifications	-	11,142	(11,937)	756	39	**0**
Impairments recognised in operating expenses	**(570)**	(1,989)	(971)	-	-	**(3,530)**
Reversal of impairments	-	736	-	-	-	**736**
Impairments recognised in revaluation reserve	-	(692)	-	-	-	**(692)**
Revaluation gain/(loss)	-	1,442	-	-	-	**1,442**
In-year depreciation transferred on revaluation	-	(953)	-	-	-	**(953)**
Disposals	-	-	(127)	(436)	-	**(563)**
At 31 March 2014	**3,050**	**27,378**	**2,992**	**10,351**	**2,005**	**45,776**
Depreciation at 1 April 2013	-	-	-	7,371	1,277	**8,648**
Provided during the year	-	**953**	-	845	226	**2,024**
In-year depreciation transferred on revaluation	-	**(953)**	-	-	-	**(953)**
Disposals	-	-	-	(436)	-	**(436)**
Depreciation at 31 March 2014	**-**	**-**	**-**	**7,780**	**1,503**	**9,283**
Net book value						
Purchased assets as at 1 April 2013	3,620	13,030	9,201	1,893	552	**28,296**
Donated assets as at 1 April 2013	-	4,464	29	239	2	**4,734**
Total at 31 March 2013	**3,620**	**17,494**	**9,230**	**2,132**	**554**	**33,030**
Purchased assets as at 31 March 2014	3,050	25,112	2,992	2,222	468	**33,844**
Donated assets as at 31 March 2014	-	2,266	-	349	34	**2,649**
Total at 31 March 2014	**3,050**	**27,378**	**2,992**	**2,571**	**502**	**36,493**

12.2 Fully depreciated assets

Fully depreciated assets with an aggregate gross carrying value of £7,613,000 are still in use.

12.3 Property, plant and equipment donated during the year

During the year, medical equipment with a value of £25,000 was donated to the trust by the Queen Victoria Hospital NHS Trust Charitable Fund (2013/14 £84,000). The League of Friends of the Queen Victoria Hospital donated medical equipment with a value of £245,000.

13. Capital commitments

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

Group and trust	**31 March 2015 £000**	31 March 2014 £000
Property, plant and equipment	**273**	328

14. Inventories

Inventories at 31 March	2014/15 Group £000	2014/15 Trust £000	2013/14 Group £000	2013/14 Trust £000
Drugs	**95**	**95**	93	93
Clinical consumables	**345**	**345**	322	322
Total	**440**	**440**	415	415

15. Trade and other receivables

15.1 Trade and other receivables comprise	31 March 2015 Current Group £000	31 March 2015 Current Trust £000	31 March 2014 Current Group £000	31 March 2014 Current Trust £000
NHS and other related party receivables	**6,050**	**6,050**	8,411	8,411
Accrued income	**1,645**	**1,645**	144	144
Provision for the impairment of receivables	**(816)**	**(816)**	(1,021)	(1,021)
Prepayments	**349**	**349**	316	316
Other receivables	**1,123**	**1,123**	1089	1,089
Total	**8,351**	**8,351**	8,939	8,939

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

15.2 Receivables past their due date but not impaired	31 March 2015 Group £000	31 March 2015 Trust £000	31 March 2014 Group £000	31 March 2014 Trust £000
By up to three months	**1,075**	**1,075**	3,831	3,831
By between three and six months	**132**	**132**	752	752
By more than six months	**332**	**332**	970	970
Total	**1,539**	**1,539**	5,553	5,553

15.3 Provision for impairment of NHS receivables	31 March 2015 Group £000	31 March 2015 Trust £000	31 March 2014 Group £000	31 March 2014 Trust £000
Balance at 1 April 2014	**(993)**	**(993)**	(712)	(712)
Amount recovered or written off during the year	**904**	**904**	10	10
Increase in receivables impaired	**(641)**	**(641)**	(291)	(291)
Balance at 31 March 2015	**(730)**	**(730)**	(993)	(993)

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

15.4 Provision for impairment of non-NHS receivables	31 March 2015 Group £000	31 March 2015 Trust £000	31 March 2014 Group £000	31 March 2014 Trust £000
Balance at 1 April 2014	**(28)**	**(28)**	(28)	(28)
Amount recovered or written off during the year	**12**	**12**	-	-
Increase in receivables impaired	**(70)**	**(70)**	-	-
Balance at 31 March 2015	**(86)**	**(86)**	(28)	(28)

16. Cash and cash equivalents

	31 March 2015 Group £000	31 March 2015 Trust £000	31 March 2014 (restated) Group £000	31 March 2014 Trust £000
Balance at 1 April 2014	**4,693**	**3,655**	9,166	8,137
Net change in year	**2,753**	**2,893**	(4,473)	(4,482)
Balance at 31 March 2015	**7,446**	**6,548**	4,693	3,655
Comprising:				
Cash with the Government Banking Service (GBS)	**6,542**	**6,542**	3,651	3,651
Commercial banks and cash in hand	**904**	**6**	1,042	4
Cash and cash equivalents as in statement of cash flows	**7,446**	**6,548**	4,693	3,655

17. Trade and other payables

	31 March 2015 Group £000	31 March 2015 Trust £000	31 March 2014 Group £000	31 March 2014 Trust £000
NHS payables	**1,096**	**1,096**	999	999
Trade payables – capital	**80**	**80**	328	328
Other payables – revenue	**1,852**	**1,852**	1,409	1,409
Accruals	**2,512**	**2,506**	973	967
	5,540	**5,534**	3,709	3,703
Tax and social security costs	**793**	**793**	793	793
Total	**6,333**	**6,327**	4,502	4,496

NHS payables include £523,000 outstanding pensions contributions at 31 March 2015 (31 March 2014 £536,000).

18. Deferred income

Current	31 March 2015 Group £000	31 March 2015 Trust £000	31 March 2014 Group £000	31 March 2014 Trust £000
Total	**436**	**436**	192	192

19. Provisions

Current	31 March 2015 Group £000	31 March 2015 Trust £000	31 March 2014 Group £000	31 March 2014 Trust £000
Pensions relating to staff	**27**	**27**	27	27
Legal claims	**1**	**1**	1	1
Contract provision	**311**	**311**	1,080	1,080
Total	**339**	**339**	1,108	1,108

Non-current	31 March 2015 Group £000	31 March 2015 Trust £000	31 March 2014 Group £000	31 March 2014 Trust £000
Pensions relating to staff	**588**	**588**	554	554

19. Provisions (cont.)

Movements in-year – group and trust	Pensions relating to staff £000	Legal claims £000	Contract provision	Total £000
At 1 April 2014	**581**	**1**	**1,080**	**1,662**
Change in discount rate	**36**	**-**	**-**	**36**
Arising during the year	**17**	**-**	**311**	**328**
Used during the year	**(27)**	**-**	**(310)**	**(337)**
Reversed unused	**-**	**-**	**(770)**	**(770)**
Unwinding of discount	**8**	**-**	**-**	**8**
At 31 March 2015	**615**	**1**	**311**	**927**

Expected timing of cash flows:				
Within one year	**27**	**1**	**311**	**339**
Between one and five years	**99**	**-**	**-**	**99**
After five years	**489**	**-**	**-**	**489**
	615	**1**	**311**	**927**

The provision for pensions relating to staff consists of £563,000 in respect of injury benefit (31 March 2014 £526,000) and £52,000 in respect of early retirements (31 March 2014 £55,000). The amounts represent the discounted future value of annual payments made to the NHS Pensions Agency calculated on an actuarial basis.

'Legal claims' are claims relating to third party and employer's liabilities. Where the case falls within the remit of the risk pooling schemes run by the NHS Litigation Authority (NHSLA), the trust's liablility is limited to £3,000 or £10,000 depending on the nature of the case. The remainder is borne by the scheme. The provision is shown net of any reimbursement due from the NHSLA.

£2,528,000 was included in the provisions of the NHS Litigation Authority at 31 March 2015 in respect of clinical negligence liabilities of the trust (31 March 2014 £1,564,000).

20. Finance expense

Interest expense	**31 March 2015 £000**	31 March 2014 £000
Loans from the Foundation Trust Financing Facility	**261**	263

21. Financial instruments

Accounting standards IAS 32, 39 and IFRS 7 require disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities.

Financial instruments are recognised and measured in accordance with the accounting policy described under note 1.10.

21.1 Financial assets and liabilities by category

All financial assets and liabilities are denominated in sterling.

Financial assets	**31 March 2015**	**31 March 2015**	31 March 2014	31 March 2014
	Group £000	**Trust £000**	Group £000	Trust £000
Loans and receivables:				
NHS and other related party receivables	**6,050**	**6,050**	8,411	8,411
Accrued income	**1,645**	**1,645**	144	144
Other receivables	**307**	**307**	68	68
Cash at bank and in hand	**7,446**	**6,548**	4,693	3,655
Total	**15,448**	**14,550**	13,316	12,278

The above balances have been included in the accounts at amortised cost as 'loans and receivables', with no financial assets being classified as 'assets at fair value through the statement of comprehensive income', 'assets held to maturity' nor 'assets held for resale'.

Financial liabilities	**31 March 2015**	**31 March 2015**	31 March 2014	31 March 2014
	Group £000	**Trust £000**	Group £000	Trust £000
Carrying value:				
Borrowings	**8,934**	**8,934**	9,711	9,711
Trade and other payables	**2,935**	**2,935**	2,736	2,736
Accrued expenditure	**2,512**	**2,506**	973	967
Total	**14,381**	**14,375**	13,420	13,414

Borrowings' represents a loan from the Foundation Trust Financing Facility provided by the Department of Health.

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

Other tax and social security cost amounts of £793,000 (2013/14 £793,000) and deferred income of £436,000 (2013/14 £192,000) are not classed as financial instruments and have therefore been excluded from the above analysis.

21.2 Maturity of financial assets

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

21.3 Maturity of financial liabilities

All of the trust's financial liabilities fall due within one year with the exception of the £8,156,000 portion of the borrowings that falls due after more than one year.

21.4 Derivative financial instruments

In accordance with IAS 39, the trust has reviewed its contracts for embedded derivatives that are required to be separately accounted for if they do not meet the requirements set out in the standard. Accordingly the trust has no embedded derivatives that require recognition in the financial statements.

21.5 Financial risk management

Because of the service provider relationship that the trust has with clinical commissioning groups and NHS England and the way those bodies are financed, the trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS trust in undertaking its activities.

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

Currency risk

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

Credit risk

Because the majority of the trust's income comes from contracts with other public sector bodies, the trust has low exposure to credit risk. The maximum exposures as at 31 March 2015 are in receivables from customers, as disclosed in note 15.

Liquidity risk

The trust's operating costs are incurred under contracts with clinical commissioning groups, which are financed from resources voted annually by Parliament. The trust is not, therefore, exposed to significant liquidity risks.

22. Related party transactions

No board members or members of the key management staff or parties related to them undertook any transactions with Queen Victoria Hospital NHS Foundation Trust during 2014/15 (2013/14 none).

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

Goods and services were bought from and sold to McIndoe Surgical Centre Ltd, a private healthcare company many of whose shareholders are consultants employed by the trust and with which the trust has a profit-sharing agreement.

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 total income and expenditure transactions with all these organisations and the debtor and creditor balances with them at the year end are shown below.

	2014/15		2013/14	
Private sector and charitable organisations	**Income £000**	**Expenditure £000**	Income £000	Expenditure £000
The Queen Victoria Hospital NHS Trust Charitable Fund	**73**	**21**	84	-
McIndoe Surgical Centre Ltd	**208**	**6**	88	2
	281	**27**	172	2

	31 March 2015		31 March 2014	
	Receivables £000	**Payables £000**	Receivables £000	Payables £000
The Queen Victoria Hospital NHS Trust Charitable Fund	**4**	**-**	-	-
McIndoe Surgical Centre Ltd	**244**	**4**	36	-
	248	**4**	36	-

22. Related party transactions (cont.)

Whole of Government Accounts bodies	2014/15		2013/14	
Bodies with whom either income or expenditure exceeded £150,000 during the year:	**Income £000**	**Expenditure £000**	Income £000	Expenditure £000
Income and expenditure				
Brighton and Sussex University Hospitals NHS Trust	**76**	**920**	903	919
Guy's and St Thomas' NHS Foundation Trust	**103**	**17**	159	
Maidstone and Tunbridge Wells NHS Trust	**258**	**68**	266	
Dartford and Gravesham NHS Trust	**2**	**718**	-	799
Medway NHS Foundation Trust	**5**	**881**	-	886
East Sussex Hospitals NHS Trust	**38**	**875**	-	826
NHS Litigation Authority	**-**	**336**	-	341
Mid Sussex District Council	**-**	**202**	-	181
Health Education England	**1,548**	**1**	782	-
NHS England	**21,055**	**7**	20,585	-
NHS Ashford CCG	**561**	**-**	473	-
NHS Bexley CCG	**554**	**-**	753	-
NHS Brighton and Hove CCG	**1,030**	**-**	1,237	-
NHS Bromley CCG	**627**	**-**	683	-
NHS Canterbury and Coastal CCG	**697**	**-**	750	-
NHS Coastal West Sussex CCG	**1,987**	**-**	2,017	-
NHS Crawley CCG	**1,583**	**-**	1,579	-
NHS Croydon CCG	**336**	**-**	396	-
NHS Dartford Gravesham and Swanley CCG	**2,423**	**-**	2,415	-
NHS East Surrey CCG	**2,786**	**-**	2,741	-
NHS Eastbourne Hailsham and Seaford CCG	**1,067**	**-**	861	-
NHS Guildford and Waverley CCG	**431**	**-**	442	-
NHS Hastings and Rother CCG	**1,695**	**-**	1,647	-
NHS High Weald Lewes Havens CCG	**3,376**	**-**	3,248	-
NHS Horsham and Mid Sussex CCG	**5,669**	**-**	5,414	-
NHS Medway CCG	**2,523**	**-**	2,464	-
NHS South Kent Coast CCG	**772**	**-**	773	-
NHS Surrey Downs CCG	**797**	**-**	748	-
NHS Swale CCG	**983**	-	1,003	-
NHS Thanet CCG	**482**	-	529	-
NHS West Kent CCG	**5,111**	-	4,777	-
	58,575	**4,025**	57,645	3,952

22. Related party transactions (cont.)

	2014/15		2013/14	
	Receivables £000	**Payables £000**	Receivables £000	Payables £000
Receivables and payables				
Brighton and Sussex University Hospitals NHS Trust	**168**	**185**	413	214
Guy's and St Thomas' NHS Foundation Trust	**76**	**6**	140	3
Maidstone and Tunbridge Wells NHS Trust	**66**	**36**	37	20
Dartford and Gravesham NHS Trust	**-**	**60**	5	73
Medway NHS Foundation Trust	**32**	**204**	28	144
East Sussex Hospitals NHS Trust	**12**	**109**	9	154
NHS Litigation Authority	**-**	**-**	-	-
Mid Sussex District Council	**-**	**-**	-	-
Health Education England	**25**	**-**	42	-
NHS England	**3,398**	**-**	3,331	62
NHS Ashford CCG	**173**	**-**	11	-
NHS Bexley CCG	**-**	**40**	48	-
NHS Brighton and Hove CCG	**-**	**161**	88	-
NHS Bromley CCG	**-**	**70**	1	-
NHS Canterbury and Coastal CCG	**62**	**-**	101	-
NHS Coastal West Sussex CCG	**102**	**-**	443	-
NHS Crawley CCG	**77**	**-**	26	-
NHS Croydon CCG	**-**	**79**	41	-
NHS Dartford Gravesham and Swanley CCG	**20**	**-**	245	-
NHS East Surrey CCG	**161**	**-**	181	-
NHS Eastbourne Hailsham and Seaford CCG	**273**	**-**	53	-
NHS Guildford and Waverley CCG	**-**	**15**	41	-
NHS Hastings and Rother CCG	**210**	**-**	346	-
NHS High Weald Lewes Havens CCG	**292**	**-**	291	-
NHS Horsham and Mid Sussex CCG	**815**	**-**	460	-
NHS Medway CCG	**268**	**-**	146	-
NHS South Kent Coast CCG	**54**	**-**	91	-
NHS Surrey Downs CCG	**69**	**-**	130	-
NHS Swale CCG	**3**	**-**	-	-
NHS Thanet CCG	**-**	**56**	-	-
NHS West Kent CCG	**636**	**-**	366	-
	6,992	**1,021**	7,114	670

23. Intra-government and other balances

Receivables: amounts falling due within one year	31 March 2015 Group £000	31 March 2015 Trust £000	31 March 2014 Group £000	31 March 2014 Trust £000
Balances with NHS bodies	**7,436**	**7,436**	8,199	8,199
Balances with other government bodies	**255**	**255**	301	301
Balances with bodies external to government	**1,476**	**1,476**	1,460	1,460
Provision for the impairment of receivables	**(816)**	**(816)**	(1,021)	(1,021)
	8,351	**8,351**	8,939	8,939

Payables: amounts falling due within one year	31 March 2015 Group £000	31 March 2015 Trust £000	31 March 2014 Group £000	31 March 2014 Trust £000
Balances with NHS bodies	**788**	**788**	983	983
Balances with other government bodies	**1,412**	**1,412**	1,377	1,377
Balances with bodies external to government	**4,133**	**4,127**	2,142	2,136
	6,333	**6,327**	4,502	4,496

24. Losses and special payments

Losses and special payments are calculated on an accruals basis.

There were four cases of losses and special payments totalling £31,000 approved during 2014/15, (ten cases totalling £1,000 in 2013/14).

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

There were no fraud cases.

25. Third party assets

The trust holds only minimal levels of third party assets usually related to patients' monies.

12 Appendices

12.1 Board of directors register

Name, title and appointment	Meeting attendance and role 2014-15					
	Board of directors	**Council of governors**	**Audit committee**	**Charitable funds advisory committee**	**Nomination and remuneration committee**	**Quality and risk committee**
Stuart Butt Interim Director of Finance and Commerce 12 May 2014 to 17 Dec 2014	7 of 7 Member	2 of 3 Attendee	4 of 4 Attendee	2 of 2 Member	–	1 of 2 Member
Ginny Colwell Non-Executive Director 1 Oct 2013 to 30 Sep 2016	12 of 12 Member	3 of 3 Attendee	5 of 5 Member	–	6 of 6 Member	5 of 5 Chairman
Steve Fenlon Medical Director 1 Apr 2013 to present	10 of 12 Member	3 of 3 Attendee	–	3 of 4 Member	–	3 of 5 Member
Peter Griffiths Chairman 1 Apr 2005 to 31 Mar 2015	10 of 12 Chairman	2 of 3 Chairman	– –	– –	6 of 6 Chairman (Q1) Member (Qs2-4)	– –
Richard Hathaway Director of Finance and Commerce 1 Apr 2010 to 9 Jun 2014	0 of 1 Member	–	–	–	–	–
Beryl Hobson Non-Executive Director and Chair Designate 1 Jul 2014 to 30 Jun 2017	8 of 9[1] Member	2 of 2 Attendee	–	2 of 2 Member	3 of 5 Member	–
Amanda Parker Director of Nursing and Quality 1 Aug 2009 to 31 Jan 2015	9 of 10 Member	1 of 3 Attendee	3 of 4 Attendee	–	–	4 of 4 Member
Lester Porter Non-Executive Director and Senior Independent Director 1 Sep 2011 to 31 Aug 2017	12 of 12 Member	3 of 3 Attendee	–	4 of 4 Chairman	6 of 6 Member (Q1) Chairman (Qs 2-4)	3 of 5 Chairman
Joanne Thomas Interim Director of Nursing and Quality 1 Feb 2015 to present	2 of 2 Member	0 of 0 Attendee	0 of 1 Attendee	–	–	2 of 2 Member
John Thornton Non-Executive Director 1 Oct 2013 to 30 Sep 2016	11 of 12 Member	3 of 3 Attendee	5 of 5 Chairman	2 of 2 Member	6 of 6 Member	– –
Dominic Tkaczyk Interim Director of Finance and Commerce 17 Dec 2014 to present	4 of 4 Member	1 of 1 Attendee	2 of 2 Attendee	2 of 2 Member	–	1 of 2 Member
Richard Tyler Chief Executive 1 Jul 2013 to present	11 of 12 Member	3 of 3 Attendee	2 of 5 Ex-officio	–	6 of 6 Member	3 of 5 Member

[1] Ms Hobson missed one meeting of the board of directors in order to attend an induction event provided by the association of NHS trusts and NHS foundation trusts and the regulator of health services.

12.2 Council of governors register

Name	Constituency	Status of current term	Start of term	End of term	Meeting attendance
Beesley, Brian[1]	Public	Re-elected 2nd term	01/07/2014	30/06/2017	2 of 3
Belsey, John	Public	Elected 1st term	01/07/2014	30/06/2017	2 of 2
Bennett, Liz	Stakeholder[2]	Appointed	01/072013	30/06/2017	2 of 3
Bowers, John	Public	Elected 1st term	01/07/2013	30/06/2016	2 of 3
Chimonas, Milton	Public	Elected 1st term	01/07/2013	30/06/2016	3 of 3
Cunningham, Mabel	Staff	Re-elected 2nd term	01/07/2011	30/06/2014	1 of 1
Cunnington, Jenny	Public	Re-elected 2nd term	01/07/2014	30/06/2017	2 of 3
Dabell, John	Public	Re-elected 2nd term	01/07/2014	30/06/2017	3 of 3
Dudgeon, Robert	Public	Elected 1st term	01/07/2013	30/06/2016	2 of 3
Glynn, Angela	Public	Elected 1st term	01/07/2014	30/06/2017	2 of 2
Goode, Brian[3]	Public	Re-elected 2nd term	01/07/2013	30/06/2016	2 of 3
Graham, Robin	Public	Elected 1st term	01/07/2011	30/06/2014	1 of 1
Harold, John	Public	Elected 1st term	01/07/2012	30/06/2015	3 of 3
Higgins, Anne	Public	Re-elected 2nd term	01/07/2014	30/06/2017	3 of 3
King, Valerie	Public	Re-elected 2nd term	01/07/2011	30/06/2014	1 of 1
Lehan, Carol	Staff	Re-elected 2nd term	01/07/2011	30/06/2014	1 of 1
Martin, Tony[4]	Public	Elected 1st term	01/07/2014	30/06/2017	2 of 2
McMillan, Moira[5]	Public	Re-elected 2nd term	01/07/2013	30/06/2016	3 of 3
Mockford, Julie	Staff	Elected 1st term	01/07/2014	30/06/2017	2 of 2
Orman, Christopher[6]	Public	Re-elected 2nd term	01/07/2014	30/06/2017	2 of 3
Rashid, Mansoor	Staff	Elected 1st term	01/07/2014	30/06/2017	1 of 2
Reader, Louise	Public	Elected 1st term	01/07/2012	30/06/2015	3 of 3
Robertson, Andrew	Stakeholder[7]	Appointed	01/07/2013	30/06/2014	2 of 3
Roche, Glynn	Public	Elected 1st term	01/07/2014	30/06/2017	1 of 2
Santi, Gillian	Public	Re-elected 2nd term	01/07/2014	30/06/2017	3 of 3
Shaw, Michael	Public	Re-elected 2nd term	01/07/2014	30/06/2017	3 of 3
Smith, Shona	Staff	Elected 1st term	01/07/2014	30/06/2017	2 of 2
Stewart, Ian[8]	Public	Re-elected 2nd term	01/07/2011	30/06/2014	0 of 1
Thomas, Alan	Public	Re-elected 2nd term	01/07/2012	30/06/2015	2 of 3
Webster, Norman	Stakeholder[9]	Appointed	01/07/2011	11/05/2015	2 of 3
Wickenden, Peter	Public	Re-elected 2nd term	01/07/2014	30/06/2017	3 of 3

Attendance figures are provided for formal meetings of the council of governors held in public, not including the annual general meeting of the trust which was held on 11 September 2014. The meeting attendance column shows attendance compared to the maximum number of meetings each governor was expected to attend within their individual terms of office.

1 As public governor representative to the charitable funds advisory committee, Brian Beesley also attended three of the four committee meetings held in 2014/15.

2 Representing West Sussex County Council.

3 As governor representative to the board of directors, Brian Goode also attended 11 of the 12 board meetings held in 2014/15.

4 Tony Martin was appointed governor representative to the quality and risk committee from October 2014 and attended three of a possible three meetings held during the remainder of 2014/15.

5 As governor representative to the quality and risk committee until September 2014, Moira McMillan attended the one meeting she was expected to in 2014/15.

6 Chris Orman was appointed to the role of vice chair and lead governor in September 2014.

7 Representing the League of Friends of the Queen Victoria Hospital

8 Ian Stewart was vice-chairman and lead governor until his term of office ended on 1 July 2014.

9 Representing East Grinstead Town Council.

12.3 Directors' biographies

Stuart Butt, Interim Director of Finance and Commerce

Stuart has worked in the NHS since 1988 and spent much of this time working at Kingston Hospital where he held several positions including deputy finance director and planning and information director. In recent years he has worked as an interim/ management consultant providing financial leadership and governance to acute, community and private healthcare organisations.

Ginny Colwell, Non-Executive Director

Ginny Colwell was appointed a non-executive director of QVH in October 2013. Ginny originally trained as a nurse and worked at Great Ormond Street Hospital. She became director of nursing at the Royal Surrey County Hospital and then corporate head of nursing for Nuffield Hospitals. She is currently also a non-executive director at Central Surrey Health and was vice chair for Phyllis Tuckwell Hospice until November 2013.

Since April 2014, Ginny has chaired the quality and risk committee, assuming responsibility from Jeremy Beech.

Dr Stephen Fenlon

Stephen was appointed QVH's medical director in April 2013. He has been a consultant anaesthetist at QVH since 2000.

After qualifying in 1988 from Nottingham University Medical School he initially followed a career in general practice before deciding to specialise in anaesthesia in 1993. In addition to his clinical commitment, he has held managerial positions at QVH since his appointment, including lead clinician for paediatric services and, since 2010, clinical director for paediatrics and clinical support services. Stephen's special interests include anaesthesia for children, research relating to pain relief following surgery, and teaching fellow healthcare professionals.

Peter Griffiths, Chairman

Peter Griffiths spent his entire career in healthcare.

His last executive appointments within the NHS were as deputy chief executive for the management executive at the Department of Health, and chief executive of the Guys and Lewisham first-wave NHS trust.

In the mid-1990s, Peter moved to the King's Fund as deputy chief executive and director of their management college. He subsequently headed up the Health Quality Service, an independent organisation providing quality development support to health services nationally and internationally. He was also president of the Institute of Health Services Management.

In 2005 he stepped down as non-executive director of the Sussex Downs and Weald Primary Care Trust, to become chairman of QVH.

Over a seven-year period, Peter was both director and subsequently chairman of the Foundation Trust Network board until stepping down in March 2013.

In June 2013, Peter was awarded a CBE in recognition of services to healthcare. Peter retired as chairman of QVH in March 2015.

Richard Hathaway, Director of Finance and Commerce

Richard Hathaway is a chartered accountant and joined QVH in 2010 from NHS South East Coast, the region's strategic health authority. Richard was director of finance at the Royal West Sussex NHS Trust for three years until 2009 and was previously the director of finance at Mid Sussex Primary Care Trust. He joined the NHS from an international accountancy practice in 1992.

Beryl Hobson, Non-Executive Director and Chair Designate

Beryl joined the trust in July 2014 as a non-executive director and chair designate and became chair in April 2015. She is the executive director of a governance consultancy, and is also chair of the National Childbirth Trust (NCT). She was previously the first chair of Sussex Downs and Weald Primary Care Trust and has more than twenty years of board level experience gained in both private, charity and NHS organisations.

Amanda Parker, Director of Nursing and Quality

Amanda Parker was appointed director of nursing and quality in August 2009, having previously held the post of deputy director of nursing.

She trained at the Middlesex Hospital, going on to specialise in renal medicine before she joined QVH as a theatre nurse in 1992. Here she developed her career in perioperative care which included a joint role with St George's in London as a lecturer practitioner.

Amanda brings strong academic and operational experience to the role. She is a registered nurse teacher with an MA in nursing and education, has an MSc in surgical and perioperative care and served as chair of the education committee on the board of the Association for Perioperative Practice (AfPP). She has extended her areas of interest and is a NICE fellow, a CQC specialist advisor and is the lead nurse representative for acute trusts on the South East Coast Clinical Senate.

In January 2015, Amanda left QVH to take up a new role with Western Sussex Hospitals NHS Foundation Trust.

Lester Porter, Non-Executive Director and Senior Independent Director

Lester Porter was appointed a non-executive director of QVH in September 2011.

He has his own executive coaching practice working with individual executives and company boards. He has also spent over ten years as an 'angel' investor in start-up businesses based in the south east and has held board positions with a number of these companies. From 2005 until 2013 he was chair of the pension fund of a publicly quoted company.

Previously he spent 30 years in a variety of management roles in the healthcare, publishing and financial services sectors, and was latterly with the Thomas Cook Group as corporate development director.

From April 2014, Lester became the senior independent director, and chair of the QVH nomination and remuneration committee. He also chairs the charitable funds advisory committee.

Jo Thomas, Interim Director of Nursing and Quality

Jo Thomas was appointed interim director of nursing and quality in February 2015, having previously held chief nurse positions in commissioning and acute provider organisations.

She trained at Brighton University Hospitals Trust and has 30 years of nursing experience in elective and emergency care, with a specialist interest and MSc in women's health.

Jo has senior management experience of leading and managing specialist services as well as extensive operational delivery and redesign of heath care services.

John Thornton, Non-Executive Director

John Thornton was appointed as a non-executive director in October 2013. He has almost 30 years' experience as a senior executive in the financial services industry. He currently works as an ombudsman for the Financial Ombudsman Service and is involved in a range of business and community activities as a consultant, non-executive director and business coach.

John has been chair of the audit committee since April 2014.

Dominic Tkaczyk, Interim Director of Finance and Commerce

Dominic Tkaczyk has been in the NHS for almost his entire working life. He is a qualified certified accountant and has been running his own consultancy business for the past 17 years.

Dominic has worked in a variety of NHS settings including acute teaching hospitals, PCTs, and an NHS England area team. His last role before joining QVH was as interim finance director for the Peterborough and Stamford NHS Foundation Trust.

Richard Tyler, Chief Executive

Richard Tyler has over twenty years of experience gained in a variety of posts within the NHS.

Richard joined QVH as chief executive in July 2013. He was previously chief executive at Hounslow and Richmond Community Healthcare NHS Trust. Richard has held roles in operational management, strategic planning and business and performance management within acute trusts, primary care trusts and at strategic health authority level. He is a member of the NHS Top Leaders programme.