NHS
Queen Victoria Hospital
NHS Foundation Trust

Annual Report, Quality Report and Accounts 2017/18

Queen Victoria Hospital NHS Foundation Trust

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1 Introduction

"We have the expertise and ability to deliver outstanding patient experience and world class clinical services whilst remaining efficient and financially sustainable."

1.1 Chair's introduction

I am pleased to present the 2017/18 annual report, quality report and accounts for Queen Victoria Hospital NHS Foundation Trust.

The Queen Victoria Hospital (QVH) has a proud heritage and is known throughout the world for pioneering new and innovative techniques and treatments. We continue to receive excellent feedback from patients and have maintained our reputation for delivering excellence.

The reputation of QVH as a centre of excellence comes from both our highly skilled clinicians and the individual attention and care shown to every patient by the whole team. Whether a patient benefits from one of the 'world-first' procedures described in our quality report or from a tried and tested treatment, as one of the smallest trusts in the country we are able to offer an exceptional patient experience and our staff are able to make a real difference.

In 2016 the Care Quality Commission rated us as 'good' with 'outstanding' patient care and we are committed to working towards every aspect of QVH being rated as outstanding. We will achieve that by continuing to work closely with our partner organisations within the NHS; we provide our expertise to neighbouring trusts and benefit from the range of clinical services and back office functions provided in our partner trusts.

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

Beryl Hobson

Chair

2 Performance

"QVH promotes a culture that encourages candour, openness and honesty at all levels"

2.1 Overview of performance

Statement from Chief Executive

On April 2016 the Care Quality Commission stated that patient care at Queen Victoria Hospital (QVH) is outstanding. The inspectors found compassionate and considerate care throughout the hospital, with numerous examples of staff going above and beyond what would be expected. The CQC reported that staff have a clear culture of compassion and an exceptionally strong awareness and empathy with patients, with excellent emotional support for both patients and carers.

This is a very high standard that we are proud to maintain. In June 2017 the national NHS inpatient survey showed that the Queen Victoria Hospital scored better than other trusts across all ten relevant sections of the survey, with top scores in areas including patients feeling well looked after by hospital staff, and being involved in decisions about their care. In November 2017 QVH was the only trust categorised as 'much better than expected' for both younger and older children in the Care Quality Commission's national children and young people's inpatient and day case survey of 132 NHS acute trusts.

QVH is an exceptional place both to receive treatment and to work. However, recruitment and retention is one of the most significant challenges facing the NHS and is impacting on QVH particularly in areas of national skills shortage. We continue to devote considerable effort to ensuring that we attract and retain the very best staff.

Patients are referred to QVH from across the south east and beyond. The vast majority of our patients get our expert clinical help swiftly, but pressures in other organisations mean we sometimes receive referrals late into a patient's pathway, challenging us to maintain our performance on access times. We have also experienced a growth in referrals which requires us to be ever more efficient in the use of our theatre time, workforce planning and the systems and processes which help us manage our waiting lists. This will be an area of continued focus in 2018/19.

Funding constraints and rising costs challenge all healthcare providers, QVH included. However careful financial stewardship has enabled us to end the year with a small surplus to invest in the future of the hospital.

We continue to work closely with partner organisations, playing a full role in the Sussex and East Surrey strategic transformation partnership as well as contributing to strategic work in Kent. As a specialist trust, we also play an important role in regional and national developments in our areas of expertise.

In a tough year for the NHS as a whole it is testament to the dedication of our staff that patient feedback remains excellent. QVH is an excellent hospital bringing together world class expertise and compassionate care. We look forward to maintaining our reputation for providing outstanding care for our patients and continuing to be a great place to work for our staff.

Statement of the purpose and activities of the Foundation Trust

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

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

In 2017/18, the principal activities of the Trust were the provision of:

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

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

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

QVH also receives referrals from these hospitals.

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

A brief history of the Foundation Trust and its statutory background

QVH is a specialist NHS hospital providing life-changing reconstructive surgery, burns care and rehabilitation services for people across the South of England. Our world-leading clinical teams also treat common conditions of the hands, eyes, skin and teeth for the people of East Grinstead and the surrounding area. In addition, we provide a minor injuries unit, expert therapies and a sleep disorders service.

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

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

Key issues and risks that could affect the Foundation Trust in delivering its objectives

The Trust has a strategy called QVH 2020: Delivering Excellence. It has developed its strategic emphasis across five domains of excellence which comprise the following key strategic objectives. These are set out below and also include details of the principle risks identified in each case.

Outstanding patient experience

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

The principal risk to delivery of this objective is the ability of the Trust to recruit and retain the right staff with the specialist skills required for caring for all our patients, especially in theatres and critical care.

World class clinical services

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

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

Operational excellence

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

The principal risk to delivery of this objective is the availability of specialist staff, especially in theatres and critical care. Other risk factors are late referrals from other trusts and less visibility of waiting lists at some spoke sites. The Trust has invested in a new data warehouse which will help with the visibility, and work is ongoing to ensure that the systems and processes for managing our waiting lists are efficient and robust.

Financial sustainability

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

The wider challenges to NHS finances and the uncertain policy environment, coupled with significant internal efficiency targets and recruitment concerns, put pressure on the Trust's ability to maintain past performance and achieve future targets. Close collaboration with partners and regulators, plus robust and effective planning are key to delivery.

Organisational excellence

In 2017/18, the board agreed a change to the wording of this key strategic objective from

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

'We seek to maintain a well led organisation delivering safe, effective and compassionate care through an engaged and motivated workforce'

which the board felt to be more reflective of the Trust's position and the intended meaning of the key strategic objective.

The principal risk to delivery of this continues to be the availability of specialist clinical staff in theatres and critical care. A detailed attraction and retention plan was agreed by the board in September 2017 and work on all aspects of this plan continue, with new actions and initiatives evolving.

Going concern

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

2.2 Performance analysis

How we measure performance

Queen Victoria Hospital (QVH) measures performance against a range of key indicators that include access targets, quality standards and financial requirements. Priority indicators are those included within the NHS Improvement Single Oversight Framework and the quality schedules of our signed contracts with commissioners.

Oversight and scrutiny of performance is achieved by the adoption and implementation of a performance framework against which the relevant directorates and managers are held to account. There are internal triggers in place so that all variances against plan are identified as early as possible, to ensure that mitigating actions are put in place. These are monitored at monthly performance review meetings by a panel of executive team members. The panel meets with the relevant clinical directors, business unit managers, human resources and finance business partners, to review each directorate's performance.

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

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

Analysis and explanation of development and performance

Governance

The board is assured, as recorded in the annual effectiveness review considered in January 2018, that an effective governance structure is in place to enable and support QVH to meet its strategic objectives and ensure compliance with regulatory requirements. The governance structures are fit for purpose and in line with best practice in the NHS and other sectors.

In July 2017 the board conducted an annual review of the standing orders and standing financial instructions, the reservation of powers and scheme of delegation.

In September 2017 the board approved a framework for the regular review of effectiveness and adequacy of its committees, including terms of reference and work plans. This programme is aligned to the work of the well-led review and will support the board's annual evaluation of its own performance in the future. The process of board subcommittee reviews has resulted in minor changes to terms of reference and internal processes.

Foundation Trust boards are required to undertake an external review of governance every three years to ensure that governance arrangements remain fit for

purpose. During 2017/18 we appointed an external team to carry out this review. In each of the eight 'key lines of enquiry' QVH demonstrated areas of good practice as well as areas for improvement. The review covered leadership and culture as well as governance and there were no material issues of concern. QVH has approached this as a positive opportunity to improve our governance effectiveness and as a result will be strengthening board reports; developing a board staff engagement plan to record the activity of board members in meeting with staff outside of their functional role; and reviewing the role of governors on committees to ensure clarity about their role.

Care quality

The Care Quality Commission (CQC) last undertook a full announced inspection of the Trust in November 2015. This included a detailed review of the quality of care and services offered by QVH based on a combination of the inspection findings, information from the CQC intelligent monitoring system, information submitted by QVH, and information given by the public and stakeholder organisations.

The overall rating for the Trust was 'good' with a rating of 'outstanding' for care.

The Trust presented a detailed response to the recommendations at a quality summit and then a formal action plan to address the small number of recommendations. This plan was monitored to completion by the quality and governance committee on behalf of the board of directors.

The Trust has received no unannounced CQC inspections during 2017/18. Assurance to our regulators about the quality of care is provided quarterly, at separate meetings with the CQC and NHS Improvement.

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

Infection control

QVH had no trust acquired cases of Clostridium difficile and no trust acquired cases of MRSA or E. Coli bacteremias in 2017/18.

Waiting times

Referral to treatment 18 open pathways

Target	Q1	Q2	Q3	Q4	2017/18 end of year position
92%	90.03%	84.43%	80.49%	77.18%	92.1%

Cancer 62 day:

Target	Q1	Q2	Q3	Q4	2017/18 end of year position
85%	73.6%	71.1%	76.5%	77.3%	74.4%

Source: Open Exeter

Waiting times have increased this year. Actions taken to address this include investment in a new data warehouse so the waiting lists of patients on all sites will be visible; work with NHS Improvement to ensure that all the relevant systems and processes are as efficient as possible; and recruitment and retention strategies particularly for clinical specialists in theatres and critical care.

Financial plan

QVH planned to deliver an operational surplus of £1.5m in 2017/18, including an expectation of a £0.9m allocation from the Sustainability and Transformation Fund (STF). The planned control total for 2017/18 is £1.7m which included the operational surplus of £1.5m plus a technical adjustment to reflect the impact of donated assets of £0.2m.

The Trust had a challenging financial year and underperformed against the clinical income plan. This was due principally to constraints within medical and theatre staffing. The underperformance was offset by expenditure underspends within pay due to unfilled vacant posts and non-recurrent non pay savings. The Trust formulated and delivered plans to address the financial gap and delivered the planned target and associated control total.

The key financial financial performance indicators for 2017/18 are detailed in the table below.

Key financial indicators	Plan £000	Actual £000
Reported financial performance	1464	3000
Control total	1716	2905
STF	942	2122

- Reported finance performance of £3.0m surplus includes an underlying performance of £2.8m plus an additional £0.2m due to the reversal of an impairment as a result of revaluation. The performance of the Trust is assessed by regulators before the impact of revaluation on the income and expenditure account.

  The Trust's reported financial performance exceeded the internal plan of £1.5m. This was principally due to additional money allocated to the Trust from the Sustainability and Transformation Fund (£1.2m) as part of the Sustainability and Transformation Fund incentive and bonus schemes and the reversal of an impairment adjustment of £0.2m due to revaluation exercise.
- The overall income and expenditure position, as detailed in the statement of comprehensive income set out in the accounts at section 6 is a surplus of £5.7m. This included the effect of revaluation adjustments to the income and expenditure account and the revaluation reserve.

Statement of comprehensive income

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

Statement of comprehensive income for the period ending 31 March 2018	2017/18 £000
Operating income	69928
Operating expenses	-65495
Operating surplus (deficit)	4433
Net finance costs	-1433
Surplus/deficit for the year	3000
Other comprehensive income:	
Revaluation gains/ losses on property plant and equipment	2680
Impairment through revaluation reserve	-26
Total comprehensive income for the period	**5654**

An independent professional valuer completed an interim (desktop) revaluation of all land, buildings and fixtures in-year. There was a £2.8m increase in the assets' values arising from the revaluation exercise, £2.6m was recognised in the revaluation reserve, and there was a £0.2m reversal of a previous impairment charge to the income and expenditure account to reflect increase in value of specific assets previously impaired.

Income

Total income for the Trust was £69.9m. The Trust received £63.0m, the majority of its income, from the provision of healthcare services. In addition, the Trust received income of £1.4m from Health Education England to support the cost of providing training and education to medical and other NHS staff, and £2.1m of Sustainability and Transformation Funding.

Operating expenses

The Trust incurred £65.5m of operating expenses in 2017/18. This includes costs of £44.3m (67% of total operating expenditure) to employ, on average over the year, 917 members of staff.

Operational non pay expenditure includes supplies and services costs of £10.5m, drug costs of £1.5m, premises costs of £2.7m, PDC (Public Dividend Capital) of £1.3m, and depreciation and amortisation of £2.8m.

Capital

Capital expenditure equated to £3.2m in 2017/18, materially in line with the agreed plan. The table below details the investments made.

Capital programme 2017/18	£000
Building and infrastructure	1,391
Medical equipment	661
Information, management and technology	661
Total	**3,162**

Cash

The Trust has a cash balance of £8.9m prior to the receipt of funds relating to the delivery of the control total, which represents c49 days of operating expenditure. The interest received by the Trust during 2017/18 was low, reflecting current economic conditions. The majority of funds are invested with the Government Banking Service (GBS).

Environmental and sustainability report

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

The key objectives with regards to sustainability are set out below and will be refreshed in 2018/19:

- To continue to reduce our carbon footprint year on year through behavioural change and introducing low carbon technologies
- To embed sustainability considerations (energy and carbon management) into our core business strategy

- To procure goods and services in a sustainable manner
- To consider the design and operation of our buildings
- To implement phased action plans to address energy, water and carbon management reduction programmes
- By recycling water, the use of grey water systems and sustainable drainage systems on the estate
- Implementation of a new waste contract and increased recycling
- Signing up to the good corporate citizenship assessment model, and actively raise awareness at every level in the Trust, and
- Staff engagement and communication.

Our carbon footprint

Our carbon footprint from gas and electricity sources during 1 April 2017- 31 March 2018 was **2757 tonnes of CO_2e.**

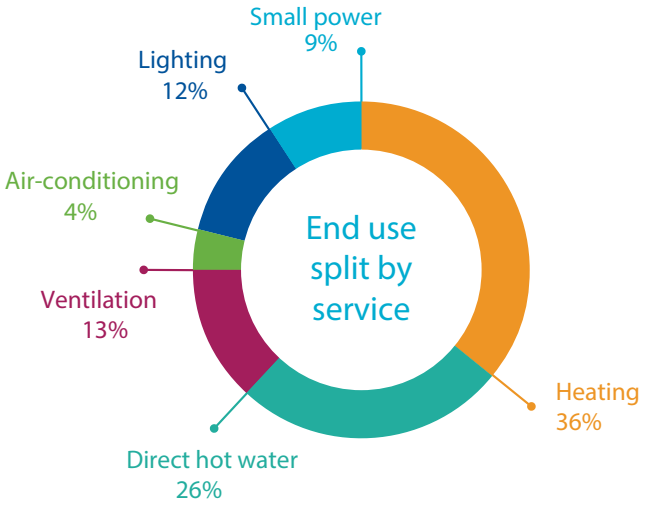
Combustion of fuel and operation of facilities	1,122
Electricity, heat, steam and cooling purchased for own use	1,635
Total	**2,757**

Total energy consumption was as follows:

Energy type	Annual kWh
Electricity	3,967,598
Gas	6,099,417

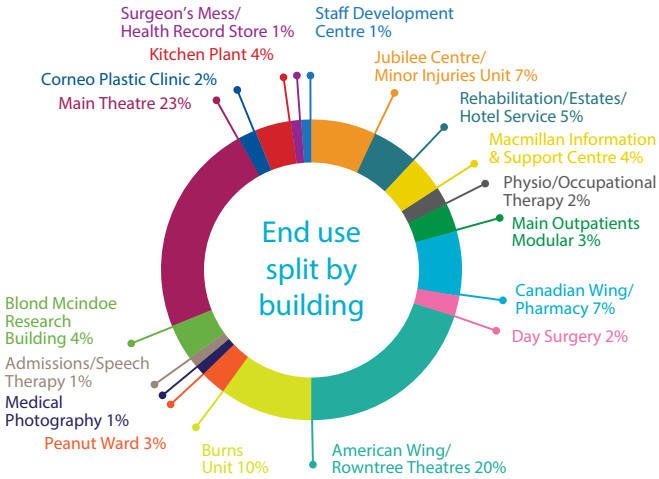
Around 60% of total energy is associated with heating and hot water, with the remaining energy use split between lighting, ventilation, air conditioning, small power and pumps.

Energy consumption by building service:



The largest proportion of energy use is associated with the theatre complex which accounts for 23% of the total.

Energy consumption by building is described below:



Building	TOTAL	%
Main Theatres	2,291,35	22.91%
American Wing/Rowntree Theatres	1,944,223	19.44%
Burns Unit	985,754	9.86%
Canadian Wing/Pharmacy	791,843	7.92%
Jubilee Centre/Minor Injuries Unit	688,959	6.89%
Rehabilition/Estates/Hotel Services	504,804	5.05%
Blond McIndoe Research Building	435,598	4.36%
Macmillan Information & Support Centre/Prosthestic Clinic	407,213	4.07%
Kitchen plant	363,979	3.64%
Main Outpatients Modular	276,566	2.77%
Peanut Ward	254,972	2.55%
Corneo Plastic Clinic	215,902	2.16%
Physio/Occupational Therapy	172,065	1.72%
Day Surgery	148,683	1.49%
Surgeon's Mess/Health Records Stores	144,891	1.45%
Admissions/Speech Therapy	123,923	1.24%
Staff Development Centre	77,718	0.78%
Medical Photography	68,693	0.69%
Paediatric Assessment Unit	59,347	0.59%
Gardeners Store	29,725	0.30%
Hurricane Café	15,077	1.15%

Specific carbon reducing projects identified for implementation in 2018/19 are:

- Investigation of overnight electricity consumption in theatres
- Installation of variable speed drives to larger fan motors where applicable
- Full review of the building management system and further enhancement of the system to monitor plant equipment across the estate
- Smart metering installation throughout the Trust to provide better data analysis on usage
- Continuation of the programme of upgrades of aged and inefficient plant, including installation of energy efficient condensing boilers
- Continuation of the programme to replace existing lighting with low energy and low maintenance LED, which will deliver savings in the region of 75% in energy consumption
- Implement active travel plan (see below) for our staff, our service users and our visitors.

Waste reduction and recycling

Recycling facilities continue to be rolled out across QVH. The current waste contract has been re-tendered, and significant improvements have been made within the new contract on waste streams and recycling. Our current waste provider treats clinical waste by incineration, with 100% steam recovery converting the heat back to energy which is supplied to six hospitals near the treatment plant. In 2017/18 120 tonnes of our waste was treated this way with 100% residual waste (flock) recovery on a further 25 tonnes.

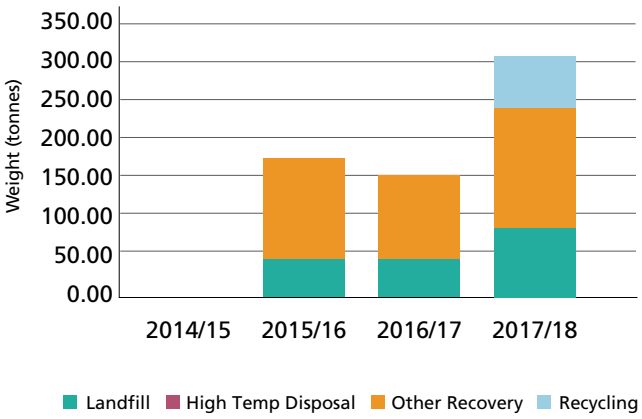
Areas for improvement include:

- Facilitating waste segregation throughout the Trust through provision of separate bins
- Increasing staff and visitor awareness of segregated waste disposal.

Waste recycling

Waste		2015/16	2016/17	2017/18
Recycling	(tonnes)	0.00	0.00	68.00
	tCO_2e	0.00	0.00	1.43
Other recovery	(tonnes)	129.00	106.00	155.00
	tCO_2e	2.58	2.23	3.26
High temp disposal	(tonnes)	0.00	0.00	0.00
	tCO_2e	0.00	0.00	0.00
Landfill	(tonnes)	44.00	44.00	85.00
	tCO_2e	10.75	13.64	26.35
Total Waste (tonnes)		173.00	150.00	308.00
% Recycled or Re-used		0%	0%	22%
Total Waste tCO_2e		13.33	15.87	31.03

Waste breakdown



Travel plan

The QVH travel plan provides a framework for the longer term management of travel to and from the hospital campus in order to encourage the use of more sustainable travel modes, reduce congestion and reduce carbon emissions, air and noise pollution. The plan was reviewed and approved by sustainable transport officers from West Sussex County Council who have responsibility for ensuring that such documents meet local travel plan requirements. The Trust expects to take action in 2018/19 to deliver the plan, including addressing the high demand for limited parking spaces on site.

Social, community, anti-bribery and human rights issues

QVH maintains close connections with the local community in East Grinstead and the surrounding areas, including regularly sharing information through the local press and engaging through social media, as well as email updates for our 7,410 Foundation Trust members. In addition the QVH governors attended a number of community meetings in 2017/18 to talk to local groups about the work of the hospital.

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

We have worked with the Healthy East Grinstead Partnership to create a model of integrated care for local people, and supported the ongoing work of the group to ensure sustainable and quality care for the people of Sussex and East Surrey through the ongoing Sustainability and Transformation Plan development processes.

Regular and open dialogue with stakeholders such as Healthwatch West Sussex gives us an additional method for ensuring we are involving and responding to our local community.

The rules and procedures relating to bribery are set out in the counter fraud policy, and those relating to the provision or receipt of gifts or hospitality are set out in the Trust's standards of business conduct policy which was updated in 2017 in line with national guidance. The Trust maintains a register of gifts, hospitality and sponsorship received and staff are made aware of the need to declare any potential conflict of interest.

Important events since end of financial year

Not applicable.

Overseas operations

QVH has no overseas operations.

Steve Jenkin

Chief Executive and Accounting Officer

24 May 2018

3 Accountability

"Our quality priorities are built around our ambitions to deliver safe, reliable and compassionate care in a transparent and measurable way"

3.1 Directors report

Directors' disclosures

In 2017/18 the following individuals served as directors of Queen Victoria Hospital NHS Foundation Trust.

Name	Position
Beryl Hobson	Chair (voting)
Ginny Colwell	Non-executive director (voting)
Lester Porter	Non-executive director (voting) and senior independent director (to 31 August 2017)
John Thornton	Non-executive director (voting) and senior independent director (from 01 September 2017)
Clare Stafford	Director of finance and performance (voting) (to 30 September 2017)
Jo Thomas	Director of nursing and quality (voting)
Ed Pickles	Medical director (voting)
Steve Jenkin	Chief executive (voting)
Gary Needle	Non-executive director (voting) (from 1 July 2017)
Kevin Gould	Non-executive director (voting) (from 1 September 2017)
Jason McIntyre	Acting director of finance and performance (voting) (from 11 September 2017 to 31 January 2018)
Michelle Miles	Director of finance and performance (voting) (from 1 February 2018)
Clare Pirie	Director of communications and corporate affairs (non-voting) (from 1 May 2017)
Sharon Jones	Director of operations (non-voting)
Geraldine Opreshko	Director of workforce and organisational development (non-voting) (substantive from 26 July 2017)

Biographies for all current directors of the Trust are provided in section 7.3. Details of company directorships and other significant interests held by directors or governors which may conflict with their management responsibilities can be accessed from the papers of meetings of the board of directors held in public.

These are available in full from the Queen Victoria Hospital (QVH) website at https://www.qvh.nhs.uk/meetings-in-public/

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

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

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

Other disclosures

In 2017/18 the Trust neither made nor received any political donations.

The better payment practice code requires QVH to pay all valid invoices within the contracted payment terms or within 30 days of receipt of goods or a valid invoice, whichever is later. The performance achieved in 2017/18 compared to 2016/17 is shown in section 6 of the annual accounts.

In 2017/18 the Trust did not incur any expenditure relating to the late payment of commercial debt under the Late Payment of Commercial Debts (Interest) Act 1998 statement describing the better payment practice code, or any other policy adopted on payment of suppliers, and performance achieved.

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

Better payment practice code	2017/18	2017/18	2016/17	2016/17
	Number	£000	Number	£000
Total Non-NHS trade invoices paid	20,090	21,583	18,533	22,571
Total Non NHS trade invoices paid within target	17,585	18,501	14,932	17,627
Percentage of Non-NHS trade invoices paid within target	**88%**	**86%**	**81%**	**78%**
Total NHS trade invoices paid	884	4,181	801	4,496
Total NHS trade invoices paid within target	521	2,020	504	2,879
Percentage of NHS trade invoices paid within target	**59%**	**48%**	**63%**	**64%**
Total NHS trade invoices paid	20,974	25,765	19,334	27,067
Total NHS trade invoices paid within target	18,106	20,520	15,436	20,505
Percentage of trade invoices paid within target	**86%**	**80%**	**80%**	**76%**

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. In 2017/18 QVH met this requirement.

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

Patient care

A detailed account of how the Trust delivers and monitors the quality of patient care can be found in the quality report which includes performance against key heath care targets, arrangements for monitoring national improvements in the quality of healthcare, patient experience.

Fees and charges

Expenditure on consultancy

During 2017/18, the Trust incurred consultancy costs of £117,000. This includes £22,000 for services supporting the development of the Sussex and East Surrey Sustainability and Transformation Plan. Further costs of £38,000 were incurred on leadership and governance advice and £51,000 for recruitment consultancy to enhance our digital presence and utilise social media to recruit to critical clinical posts.

In 2017/18 QVH appointed Frontline to carry out a review of leadership and governance in accordance with national requirements. Frontline is an external management consultancy and has no connection with the Trust. No issues of material concern were identified. Board members have worked through the outputs of this review in detail and we will be building on the many areas of good practice and addressing areas where practice can be improved.

Steve Jenkin

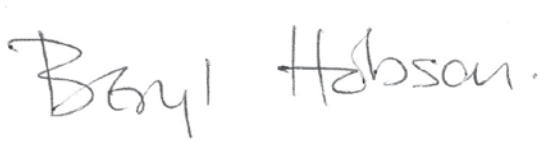
Chief Executive and Accounting Officer
24 May 2018

3.2 Remuneration report

Annual statement on remuneration

In 2017/18 the nomination and remuneration committee reviewed its approach to very senior management (VSM) pay based on updated guidance and salary benchmarks from NHS Improvement. The committee was assured that the Trust was in step with comparable benchmarked trusts at the median level. The salaries of the director of finance and director of nursing increased by 1% in line with the nationally determined Agenda for Change pay increase. The director of operations remuneration was increased more significantly to reflect a restructure of operational service and an increase in the span of control and accountability. During the year the Trust also appointed to the substantive positions of director of workforce and organisational development, and director of

communications and corporate affairs with pay being set with reference to median benchmarked levels.



Beryl Hobson

Trust Chair and Chair of the nomination and remuneration committee

24 May 2018

Senior managers' remuneration policy

The salary and pension entitlements of senior managers are set out in the section below showing information subject to audit. The QVH approach to remuneration continues to be influenced by national policy and local market factors. The majority of staff receive pay awards determined by the Department of Health in accordance with their national terms and conditions, such as Agenda for Change, and the pay review bodies for doctors and dentists. All junior doctors at QVH are now on the new contract.

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

All senior managers' pay arrangements are subject to approval by the nomination and remuneration sub-committee of the board of directors.

In relation to agreeing and reviewing very senior managers (VSM) pay, as national guidelines from the previous Trust Development Authority (TDA) and Monitor have now been amalgamated into one document, updated in April 2017, 'Guidance on pay for very senior managers in NHS trusts and foundation trusts' the remuneration and nomination committee agreed that it would use the very clear guidance available from NHS Improvement when reviewing VSM pay rather than agree a stand-alone QVH strategy.

The members of QVH nomination and remuneration Committee agreed simple principles in relation to setting, agreeing and reviewing VSM pay. For new director appointments the director of workforce will review benchmarking data as well as seek market intelligence on the salaries being offered to directors which will also take account of supply and demand at that time. The review of existing VSM pay will take place once a year, usually around May/June and will take account of:

- The outcome of annual appraisal conducted by the Chief Executive (or Chair in the case of the Chief Executive's pay)
- The level of the national pay award for the workforce on Agenda for Change
- Any extenuating circumstances/market conditions highlighted by the Chief Executive
- Updated benchmarking information and guidance.

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

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

Senior managers paid more than £150,000

During the year no senior manager was paid more than £150,000.00.

Non-executive directors table

The salary and pension entitlements on non-executive directors are set out in the table below showing information subject to audit.

Service contract obligations

None to disclose.

Policy on payment for loss of office

Termination payments are made within the contractual rights of the employee and are therefore subject to income tax and national insurance contributions.

This applies to senior managers whose remuneration is set by the nomination and remuneration committee. Where a senior manager receives payment for loss of office, this is determined by their notice period. For all executive directors the notice period is three months and the chief executive six months.

Statement of consideration of employment conditions elsewhere in the foundation trust

The Trust, through the nomination and remuneration committee, takes into account the annual pay awards for all staff in determining pay increases for senior managers and directors. Pay at senior levels was reviewed in 2017/18 and the nomination and remuneration committee approved an increase of 1% to the pay of two members of the executive team which was in line with the pay award made to staff on the Agenda for Change terms and conditions and took into account both NHS Improvement and NHS Providers benchmarking of very senior management pay across the UK. One director received a pay award greater than this due to a restructure and significant increase in span of control and responsibility and this was in line with benchmarking reports.

The comparisons considered were basic salary for the post in similar NHS hospitals and variations by geographic location. The Trust does not pay bonus payments to any senior managers and therefore the comparison with basic pay at other trusts is appropriate in determining pay increases.

Annual report on remuneration

Information not subject to audit:

Name	Position	Start date	Term	Notice period
Steve Jenkin	Chief executive	14 November 2016	Permanent	6 months
Geraldine Opreshko	Director of workforce and organisational development	26 July 2017	Permanent	3 months
Sharon Jones	Director of operations	1 June 2015	Permanent	3 months
Ed Pickles	Medical director	1 October 2016	Permanent	3 months
Clare Pirie	Director of communications and corporate affairs	1 May 2017	Permanent	3 months
Clare Stafford	Director of finance and performance	1 June 2015 (left 30 September 2017)	Permanent	3 months
Jo Thomas	Director of nursing and quality	15 May 2015	Permanent	3 months
Michelle Miles	Director of finance and performance	1 February 2018	Permanent	3 months

Remuneration committee

The nomination and remuneration committee met three times in 2017/18 to review and make recommendations to the board of directors on the composition, balance, skill mix, remuneration and succession planning of the board. Additionally, the committee makes recommendations on the appointment of executive directors. The May and November meetings ratified the appointment and remuneration packages further to the substantive appointments of the director of communications and corporate affairs and director of workforce respectively. The board of directors has delegated authority to the committee to be responsible for the remuneration packages and contractual terms of the chief executive, executive directors and other senior managers reporting to the chief executive.

Details of the membership of the nomination and remuneration committee and of the number of meetings and individuals' attendance at each is disclosed in appendix 7.1.

The committee was materially assisted in its considerations at all meetings held in 2017/18 by Geraldine Opreshko, Director of Workforce and Organisational Development.

Disclosures required by the Health and Social Care Act

Directors

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

Governors

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

1 April 2017 – 31 March 2018		
Total number of governors in office	**Number of governors receiving expenses in 2017/18**	**Aggregate sum of expenses paid in 2017/18 (rounded to the nearest £00)**
32 served for all or part of 2017/18	0	0

Information subject to audit

Salary and pension entitlements of senior managers							
A) Remuneration	**2017/18**						
Name and title	**Salary & fees (in bands of £5k)** £000s (Band of £5k)	**Benefits in kind** £s (nearest £100)	**Annual performance** £000s (Band of £5k)	**Long-term performance** £000s (Band of £5k)	**All pension-related benefits** £000s (Band of £2.5k)	**Other remuneration** £000s (Band of £5k)	**Total** £000s (Band of £5k)
Colwell V (Non-Executive Director)	10-15	700	-	-	-	-	15-20
Gould K (Non-Executive Director) With effect from 1 September 2017	5-10	100	-	-	-	-	5-10
Hobson B (Chair)	40-45	1,100	-	-	-	-	45-50
Jenkin S (Chief Executive)	135-140	0	-	-	30.0-32.5	-	170-175
Jones S (Director of Operations)	115-120	0	-	-	115.0-117.5	-	230-235
Mcintyre J (Interim Director of Finance) With effect from 11 September 2017 to 30 January 2018	35-40	0	-	-	27.5-30.0	-	65-70
Miles M (Director of Finance) With effect from 5 February 2018	15-20	0	-	-	2.5-2.5	-	20-35
Needle G (Non-Executive Director) With effect from 1 July 2017	10-15	0	-	-	-	-	10-15
Opreshko G (Director of Workforce & OD) Substantive post of Director of Workforce and OD on 26 July 2017	95-100	0	-	-	22.5-25.0	-	120-125
Pickles E (Medical Director)	140-145	0	-	-	77.5-80.0	-	220-225
Pirie C (Director of Communications and Corporate Affairs) With effect from 1 May 2017	65-70	0	-	-	92.5-95.0	-	160-165
Porter L (Non-Executive Director) Until 15 September 2017	5-10	0	-	-	-	-	5-10
Stafford C (Director of Finance) Until 30 September 2017	60-65	0	-	-	15.0-17.5	-	75-80
Thomas J (Director of Nursing and Quality)	105-110	0	-	-	-	-	105-110
Thornton J (Non-Executive Director	10-15	0	-	-	-	-	10-15
*Salary attributable to medical director's clinical role is £127,732							

Salary and pension entitlements of senior managers

A) Remuneration

Name and title	2016/17 Salary & fees (in bands of £5k) £000s (Band of £5k)	Benefits in kind £s (nearest £100)	Annual performance-related bonus £000s (Band of £5k)	Long-term performance-related bonus £000s (Band of £5k)	Pension-related benefits £000s (Band of £2.5k)	Other remuneration £000s (Band of £5k)	Total £000s (Band of £5k)
Colwell V (Non-Executive Director)	10-15	300	0	0	0	0	15-20
Fenion S (Medical Director)	75-80	0	0	0	0	0	75-80
Hobson B (Chair)	40-45	600	0	0	0	0	45-50
Jenkin S (Chief Executive)	50-55	0	0	0	10-12.5	0	65-70
Pickles E** (Medical Director)	70-75	0	0	0	95-97.5	0	165-170
Porter L (Non-Executive Director)	10-15	0	0	0	0	0	10-15
Stafford C (Director of Finance)	125-130	100	0	0	37.5-40	0	165-170
Thomas J (Director of Nursing)	105-110	0	0	0	42.5-45	0	150-155
Thornton J (Non-Executive Director)	10-15	0	0	0	0	0	10-15
Tyler R (Chief Executive)	95-100	0	0	0	40-42.5	0	135-140

*Salary attributable to medical director's clinical role is £71,078

**Salary attributable to medical director's clinical role is £63,233

Salary and pension entitlements of senior managers

B) Pension benefits

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Lump sum at age 60 related to real increase in pension (bands of £2,500) £000	Total accrued pension at age 60 at 31-Mar-18 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31-Mar-18 (bands of £5,000) £000	Cash equivalent transfer value at 01 April 2017 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value at 31-Mar-18 £000
Jenkin S (Chief Executive)	2.5-5	0	0-5	0	15	39	54
Jones S (Director of Operations)	5-7.5	17.5-20	45-50	140-145	827	146	982
McIntyre J (Acting Director of Finance)	0-2.5	5-7.5	25-30	65-70	359	63	426
Miles M (Director of Finance)	0-2.5	0-2.5	25-30	70-75	362	9	375
Opreshko G (Director of Workforce and OD)	0-2.5	0-2.5	0-5	0	8	22	30
Pickles E (Medical Director)	2.5-5	5.0-7.5	35-40	95-100	497	74	576
Pirie C (Director of Communications and Corporate Affairs)	2.5-5	10-12.5	15-20	35-40	184	74	260
Stafford C (Director of Finance)	0-2.5	0	30-35	80-85	184	52	525
Thomas J (Director of Nursing and Quality)	0-2.5	10-12.5	30-35	100-105	600	67	673

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

No performance related bonus was paid in 2017/18 or 2016/17.

Clare Stafford left the Trust on 30 September 2017.

Michelle Miles was appointed to the substantive post of director of finance and performance on 1 February 2018.

Clare Pirie was appointed to the substantive post of director of communications and corporate affairs on 1 May 2017.

Geraldine Opreshko was appointed to the substantive post of director of workforce and organisational development on 26 July 2017.

Lester Porter left the Trust on 31 August 2017.

Gary Needle was appointed non-executive director for a three-year term on 1 July 2017.

Kevin Gould was appointed non-executive director for a three year term on 1 September 2017.

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

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

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

The banded remuneration of the highest paid director in QVH in the financial year 2017/18 was £140k to £145k (2016/17, £130k to £135k). This was 5.1 times (2016/17, 4.8 times) the median remuneration of the workforce, which was £28k (2016/17, £28k).

In 2017/18, 15 (2016/17, 12) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £143k to £210k (2016/17 £142k-£206k).

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

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.

Steve Jenkin

Chief Executive and Accounting Officer

24 May 2018

3.3 Remuneration report

Average staff numbers

The table below shows the average number of staff employed by the Trust each month in 2017/18.

Permanently employed 2017/18 data													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average
Headcount	961	976	976	970	973	978	992	997	988	979	980	981	**979**
FTE	818.84	825.25	831.55	828.91	829.01	832.35	844.29	850.21	843.50	834.73	833.97	836.86	**834.12**
Temporary staff-bank, locum, agency													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average
Non-medical bank	40.37	44.05	48.6	47.6	47.05	42.02	40.4	47.11	40.4	58.13	58.16	65.26	**48.26**
Non-medical agency	14.50	13.29	16.92	24.54	28.60	28.30	27.57	30.53	26.00	32.83	36.44	42.33	**26.82**
Medical locums	1.56	5.96	4.15	2.71	5.4	2.31	3.51	5.67	10.91	4.62	4.54	5.18	**4.71**
Medical bank	1.21	2.02	1.79	0.84	2.8	1.64	2.06	1.92	5.09	0.93	1.47	0.87	**1.89**
Medical agency	1.52	1.86	0.46	1.10	0.00	0.23	0.55	0.43	0.95	0.93	1.84	0.18	**0.84**
Total average full time equivalent staff numbers 2017/18													**916.64**

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

The table below shows the gender breakdown in the Trust.

2017/18 data	Chief executive	Executive directors	Non-executive directors	Other senior managers	All other employees	Total
Female	0	2	2	3	742	749
Male	1	1	3	0	235	240
Total						**989**

Sickness absence data

In line with national guidance, the table shows the sickness absence for the calendar year January-December 2017.

	Total days lost	Total WTE staff years available	Average number of days of sickness absence per WTE employee
2017/18	5,379	838	6
2016/17	5,606	850	7

Employee benefits and staff numbers	2017/18 £000	2016/17 £000
Salaries and wages	34,918	33,454
Social Security Costs	3,756	3,406
Employer's contributions to NHS pension scheme	4,052	3,942
Employer's contributions to other pension schemes	4	-
Agency/contract staff	2,289	2,947
Employee benefits expense	45,020	43,749

Recoveries in respect of seconded staff	(410)	(447)
Costs capitalised as part of assets	(326)	(669)
Employee benefits expense	44,284	42,633

Average number of people employed	2017/18 Trust Number	2016/17 Trust Number
Medical and dental	154	146
Administration and estates	286	279
Healthcare assistants and other support staff	128	123
Nursing, midwifery and health visiting staff	199	198
Scientific, therapeutic and technical staff	60	61
Healthcare science staff	99	104
Total	926	911
Of which - number of employees (WTE) engaged on capital projects	2	7

Staff policies and actions applied during the financial year

During 2017/18, QVH continued to ensure all staff policies are systematically reviewed and updated and comply with changes in legislation, and that employment policies are in line with current good practice and ensure that applicants and employees are treated fairly and equitably. Key staff policies reviewed in 2017/18 include:

- Relocation Policy
- Social Media Policy
- Disciplinary Policy
- Flexible Working Policy
- Payment of Salaries and Wages Policy
- Drugs and Alcohol Abuse Policy
- Policy and Procedure for Exception Reporting and Work Schedule Review.

Other action taken in year included the provision of:

- further improvements to the appraisal scheme and toolkit
- a change in approach to induction for new employees
- the approval and implementation of a multi-faceted staff engagement and retention plan.

Policies applied during the financial year for giving full and fair consideration to applications for employment made by disabled persons, having regards to their particular aptitudes and abilities	QVH has a positive approach to applications from people with disabilities and makes adjustments where appropriate for interview and employment. The Trust is registered as a 'Disability Confident Employer' in 2017/18, and analysis shows that a higher proportion of disabled applicants are being shortlisted in relation to their comparator group as those who meet the minimum essential criteria are guaranteed an interview as a part of this accreditation.
Policies applied during the financial year for continuing the employment of, and arranging appropriate training for, employees who have become disabled persons during the period	The Trust continues to provide training sessions and ongoing support for managers and staff around disability, including a successful programme around mental wellbeing. Our occupational health provider is very supportive of our disabled staff and is working with managers to ensure reasonable adjustments are made when recommended
Policies applied during the financial year for training, career development and promotion of disabled employees	Delivery of training is under regular review as part of the Trust's equality strategy action plan and implementation of the Equality Delivery System 2. QVH works with disabled staff as individuals, discussing their needs on a case-by-case basis. QVH is registered with the 'Disability Confident' scheme and is committed to deliver against the NHS Employers recommended Workforce Disability Equality Standard within the next year.
Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees	During 2017/18 the executive team hosted regular all staff briefing sessions. Chaired by the chief executive, the sessions included briefings on the Trust's latest quality, operational, financial and workforce performance metrics and analysis. There were also a number of 'QVH Conversations' hosted by the Chief Executive following on from the staff survey results to enable individuals to comment further on their experience of working at the Trust and where improvements could make a difference. Leadership 'Team Brief' was launched in 2017/18, providing face to face cascade briefing through the organisation. The Chief Executive writes a monthly blog which directly encourages comment from staff and continues to receive helpful feedback. A weekly staff newsletter provides an effective method of communication. Important news and developments are reported to staff in real time by email whenever necessary. The intranet site for staff is being further enhanced to improve navigation and appearance and also includes new pages for clinical and medical education.
Actions taken in the financial year to consult with employees and their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests	QVH has good working relationships with its staffside representatives and meets with them regularly to discuss the performance of the Trust in terms of its financial position and continuous improvement of care quality, workforce challenges and so on. Formal consultation with staff is driven through the joint consultation and negotiating committee comprising trade union and management representatives; and local negotiating committee involving managers and medical staff representatives and including a British Medical Association representative.
Actions taken in the financial year to encourage the involvement of employees in the NHS foundation trust's performance	During 2017/18 breakfast sessions with the Chief Executive and Chair and staff have been increasingly utilised by staff and also expanded to afternoon tea to facilitate access to different staff groups. The team brief approach has been implemented and a range of other initiatives were successfully revitalised including staff excellence awards and recognition for long service as well as a summer barbeque supported by the QVH Charity. There are monthly meetings of a Hospital Management Team, newly formed, with senior clinical leaders from across the Trust involved in strategy and decision making.

	Whilst QVH has an open and supportive culture, it is important that we also provide other opportunities for staff to raise concerns safely without fear. The Trust successfully appointed a Freedom to Speak up Guardian. The individual was elected by the workforce.
Information on health and safety performance and occupational health	QVH has a health and safety committee which regularly receives reports from across the Trust highlighting any risks and how they are being addressed. In addition, the human resources department provides quarterly information on the support provided to staff through our occupational health and employee assistance providers. Data on this is also included the workforce reports to board and committees of the board. Our occupational health services are provided by a neighbouring trust, Surrey and Sussex Healthcare (SASH). We have seen a number of enhancements to the services including an improved triage service, improved reporting and record keeping, enhancements to key policies, improvements in health surveillance and access to support seven days a week. We contract directly now for a more cost effective employee assistance provider. This provides all staff with a range of personal and professional support, including: confidential counselling and legal advice for both work related and non-work issues; stress management; advice to staff on injuries at work; and a 24-hour employee assistance programme which provides comprehensive, round the clock phone advice for all staff including legal advice and access to an online well-being portal.
Information on policies and procedures with respect to countering fraud and corruption	QVH takes fraud and corruption very seriously and takes steps to regularly review processes to ensure that opportunities for fraud to take place are minimised. This includes training sessions for staff and managers from the counter fraud team. We also act upon information provided by staff and encourage them to be open at all times where they feel their colleagues are not acting in the best interests of patients or the Trust. NHS Protect training has been revised and an annual counter fraud survey undertaken.

The board of directors is provided with an annual report on progress against the equality strategy and the Trust publishes data relating to its equality profile 31 on the website. Detailed work behind the Workforce Race Equality Standard and preparation for the Workforce Disability Equality Standard is underway. Employee policy and service developments in the Trust require an Equality Impact Assessment (EqIA) to encourage reflection on potential impacts to those with protected characteristics and human rights principles. As part of continued advancements the EqIA process is now embedded within the business case development process, and updated guidance for managers on carrying out these assessments has been shared.

Retention and attraction challenges

The significant workforce challenges across the NHS impacted on the Trust during 2017/18. This has been demonstrated in the turnover of clinical staff, particularly nursing staff in theatres, critical care and paediatrics, and also reflected in the staff survey and staff friends and family feedback. The Trust is also aware that we have an ageing workforce with a relatively high proportion of staff who could retire in the near future.

NHS Employers and NHS Improvement have stated that workforce is the single biggest challenge and risk in the NHS nationally. In summer 2017 we were invited to participate in the NHS Improvement Retention Support Programme with the objective of improving staff retention in NHS trusts and bringing down the leaver rates.

The Trust board agreed to an ambitious multi-faceted engagement and retention programme linked to a number of KPIs. Progress in delivering the various aspects of this programme has been well received in many areas by existing clinical staff, however attraction remains a challenge as all local trusts are targeting the same staff groups with similar incentives and in our geographical location we are disadvantaged by high cost of living and supplements offered by other trusts.

Staff survey results

Commentary

Our staff engagement score dropped slightly in the 2017 staff survey to 3.85, down from 3.87 in 2016. The average for specialist trusts in the QVH comparator group is 3.95, down from 3.98 in 2016. The overall engagement score for acute trusts in 2017 was 3.78.

Changes in the external NHS environment have continued to impact on QVH in the last 12 months and the Trust has experienced nursing retention challenges, particularly in theatres, leading to a higher usage of temporary staff.

Almost 55% of the total workforce responded to the survey, a similar number to 2016. Survey results have also shown staff continuing to recommend QVH as a place to receive treatment at 88%, this is a slight reduction from 91% in 2016. There continues to be a decline in general job satisfaction, 57% in 2017 compared to 62% in 2016, compared to 72% across the benchmark group.

Summary of performance – results from the NHS staff survey

Of the 88 questions in the survey the Trust scores significantly better on 5 questions, worse on 1, and no significant difference in the remaining 82 questions.

The areas of significant improvement were:

	2016	2017
Immediate manager gives clear feedback on my work	54%	65%
Immediate manager supportive in personal crisis	68%	74%
Immediate manager takes positive interest in my well being	60%	69%
Senior managers try to involve staff in important decisions	25%	31%
Had appraisal/KSF review in last 12 months	83%	87%

There was a decline in staff feeling that they were able to provide the care that they aspire to, down to 68% in 2017 from 74% in 2016. This is felt to be attributable to pressure from additional activity and areas of staff shortages as well as a number of non-clinical staff responding to this question.

The Trust continues to use the staff friends and family test as a means to triangulate some of the outcomes of the survey.

Response rate				
	2016	2017		Trust improvement/deterioration
	Trust	Trust	Benchmarking group (specialist)	
Response rate	56%	55%	53%	stable

Top 5 ranking scores				
	2016		2017	Trust improvement/ deterioration
	Trust	Trust	Benchmarking group (specialist) average	
KF27 – Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse (higher the the better)	47%	50%	47%	improvement
KF26 – Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months (lower the better)	22%	22%	23%	stable
KF32 – Effective use of patient/service user feedback (higher the better)	3.80	3.84	3.84	improvement
KF17 – Percentage of staff feeling unwell due to work related stress in the last 12 months (the lower the better)	32%	35%	35%	improvement
KF21 – Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion (higher the better)	86%	87%	88%	improvement

Bottom 5 ranking scores				
	2016		2017	Trust improvement/ deterioration
	Trust	Trust	Benchmarking group (specialist) average	
KF15 Percentage of staff satisfied with flexible working patterns (higher the better)	49%	47%	54%	decrease
KF13 – Quality of non-mandatory training, learning or development (higher the better)	3.89	3.89	4.08	stable
KF3 – Percentage of staff agreeing that their role makes a difference to patients/service users (higher the better)	91%	89%	91%	decrease
KF25 – Percentage of staff experiencing harassment, bullying or abuse from patients, relative or public in the last 12 months (lower the better)	23%	25%	21%	deterioration
KF7 – Percentage of staff able to contribute towards improvements at work (higher the better).	70%	68%	73%	decrease

Off payroll engagements

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

In the financial year 2017/18 the Trust has had no off-payroll arrangements.

All off-payroll engagements as of 31 March 2018, for more than £245 per day and that last for longer than six months	
	Number
Number of existing engagements as of 31 March 2018	0
Of which:	
Number that have existed for less than one year at the time of reporting	0
Number that have existed for between one and two years at the time of reporting	0
Number that have existed for between two and three years at the time of reporting	0
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	0
All existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.	Not applicable

All new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months	
	Number
All new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months	0
Of which:	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to Trust) and are on the Trust's payroll	0
Number of engagements reassessed for the consistency/assurance	0
Number that saw a change to IR35 status following the consistency review	0

Any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018	
Number of off-payroll engagements of board members, and /or senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on payroll engagements	8

Exit packages

Foundation trusts are required to disclose summary information on the use of exit packages agreed in the financial year. Staff exit packages are payable when the Trust terminates the employment of an employee before the normal retirement date or whenever an employee accepts voluntary redundancy in return for these benefits. In 2017/18 QVH did not make any compulsory redundancies and agreed two payments in lieu of notice. There was a resource cost of £12k for staff exit packages in 2017/18.

2017/18			
	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
Total number of exit packages by type	0	2	2
Total cost (£000)	0	12	12

2017/18			
	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
Less than £10,000	0	2	2
Total number of exit packages by type	0	2	2
Total cost (£000)	0	12	12

Non-compulsory departure payments

In 2017/18 QVH did not make any compulsory redundancies and agreed two payments in lieu of notice.

2017/18 Lieu of notice		
	Agreement number	Total value of agreements £000
Contractual payments in lieu of notice	2	12

Trade union facility time regulations (2017)	
Table 1 – Relevant union officials **What was the total number of your employees who were relevant union officials during the relevant period?**	
Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
6	5.09

Table 2 – Percentage of time spent on facility time **How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?**	
Percentage of time number of employees	Number of employees
0%	
1-50%	6
51%-99%	
100%	

Table 3 – Percentage of pay bill spent on facility time **Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.**	
First column	Figures
Provide the total cost of facility time	£6,075
Provide the total pay bill	£44,284,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.014%

Table 4 – Paid trade union activities **As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?**	
Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	0%

3.4 NHS foundation trust code of governance disclosures

Statement

Queen Victoria Hospital NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain basis'. The NHS Foundation Trust Code of Governance most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

	Part of schedule A (see above)	Relating to	Code of Governance reference	Summary of requirement
1.	2: Disclose	Board and Council of Governors	A.1.1	The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the Council of Governors. This statement should also describe how any disagreements between the Council of Governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the Council of Governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.
The schedule of matters reserved for the Board of Directors was updated in 2016/17 following a review of the Trust's standing orders and standing financial instructions, and is published to the Trust's website. This suite of documents was implemented from 1 July 2017. The schedule includes a series of statements detailing the roles and responsibilities of the council of governors. Separate standing orders for the council of governors are in place. The Trust's annual plan for 2013/14 described how any disagreements between the council of governors and the board of directors will be resolved and still stands. It is supported by the Trust's constitution and standing orders (also published to the Trust's website) to provide the framework for decision making and delegation between the board of directors, council of governors and executive management team				
2.	2: Disclose	Board, Nomination Committee(s) Audit Committee, Remuneration Committee	A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors. Part of this requirement is also contained within paragraph 2.22 as part of the directors' report.
A register of this information is at section 7.1.				
3.	2: Disclose	Council of Governors	A.5.3	The annual report should identify the members of the Council of Governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.
A register of this information is at section 7.2.				
4.	Additional requirement of FT ARM	Council of Governors	n/a	The annual report should include a statement about the number of meetings of the Council of Governors and individual attendance by governors and directors.
A register of this information is at sections 7.1 and 7.2.				
5.	2: Disclose	Board	B.1.1	The Board of Directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.
A register of this information is at section 7.1.				
6.	2: Disclose	Board	B.1.4	The Board of Directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the Board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.
Directors' biographies are included at appendix 7.3. The Trust considers that the board of directors remains balanced, complete, appropriate and compliant with the provisions of the NHS Foundation Trust Code of Governance and its own terms of authorisation.				

	Part of schedule A (see above)	Relating to	Code of Governance reference	Summary of requirement
7.	Additional requirement of FT ARM	Board	n/a	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated.
Details of the length of appointments of the non-executive directors are included at appendix 7.1 . Paragraph 35 of the Trust's constitution sets out the criteria and process for termination of a non-executive director contract.				
8.	2: Disclose	Nominations Committee(s)	B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.
See section 3.2.				
9.	Additional requirement of FT ARM	Nominations Committee(s)	n/a	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.
Not applicable.				
10.	2: Disclose	Chair/Council of Governors	B.3.1	A chairperson's other significant commitments should be disclosed to the Council of Governors before appointment and included in the annual report. Changes to such commitments should be reported to the Council of Governors as they arise, and included in the next annual report.
A register of directors' interests is kept by the Trust and is available at any time on request from the deputy company secretary. This register is also included in full in the papers for meetings of the board of directors held in public.				
11.	2: Disclose	Council of Governors	B.5.6	Governors should canvass the opinion of the Trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the Board of Directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.
The QVH outlook for 2017/18 was presented at the annual members' meeting held on 31 July 2017, to which all members were invited. Regular information on strategy and development is included in the Trust's newsletter for members and the general public and in email bulletins to members. The Council of Governors receives regular presentations by the Chief Executive and Executive team, providing an overview of the national and local position. These lead to an informed discussion of forward plans. The governor representative model means selected governors join the Board and its committees where they have the opportunity to contribute further to the forward plans. The Sustainability Transformation Partnerships are an important part of our current environment. Council has been updated regularly about what this means for QVH and how they can disseminate this information to members.				
12.	Additional requirement of FT ARM	Council of Governors	n/a	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)
Not applicable.				
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.

	Part of schedule A (see above)	Relating to	Code of Governance reference	Summary of requirement
At its meeting in January 2018, the board considered an internal evaluation report which covered the collective performance of the board, the performance of its committees and the individual performance of its directors. The board was assured by this review that the Trust's governance arrangements remained fit for purpose. The performance of the executive directors is assessed by the chief executive taking into account feedback sought from relevant members of staff and the board. The performance of the non-executive directors is assessed by the chair taking into account feedback sought from the executive directors and governors. The performance of the chair is assessed by the senior independent director in collaboration with the chair of the council of governors' appointments committee taking into account feedback sought from directors and governors, particularly the council's governor representatives to the board and its sub-committees. Processes for performance evaluation for directors and the chair continue to be refined on an annual basis to ensure input remains meaningful.				
14.	2: Disclose	Board	B.6.2	Where there has been external evaluation of the Board and/or governance of the trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.
Compliant. In 2017/18 QVH appointed Frontline, an external management consultancy, to carry out a review of leadership and governance in accordance with national requirements. (See 3.1 Other disclosures)				
15.	2: Disclose	Board	C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). See also ARM paragraph 2.92.
See the annual governance statement at section 3.7.				
16.	2: Disclose	Board	C.2.1	The annual report should contain a statement that the Board has conducted a review of the effectiveness of its system of internal controls.
See the annual governance statement at section 3.7.				
17.	2: Disclose	Audit Committee/ Control Environment	C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.
In 2017/18 the Trust's internal audit function was provided by Mazars Public Sector Internal Audit Limited; a subsidiary of Mazars LLP. The purpose of internal audit is to provide the Trust board, via the audit committee, with an independent and objective opinion on risk management, internal control and governance arrangements. The scope of coverage in 2017/18 included: • Governance • Clinical/patient safety • Financial control • Information and Management technology • Human resources • Estates and facilities.				

	Part of schedule A (see above)	Relating to	Code of Governance reference	Summary of requirement
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 2017/18.				
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 (incl uding financial, clinical, operational and compliance controls and risk management systems). The committee is also responsible for maintaining an appropriate relationship with the Trust's auditors.

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

During 2017/18

- 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.
- Following the appointment of a new Chair in September 2017, the Committee undertook an in-depth review of its effectiveness and terms of reference. Its work programme was also reviewed and updated during the last quarter of the financial year to ensure it remained relevant and meaningful.
- The internal auditors were able to report full or substantial assurance for 92% of the areas reviewed. The overall opinion is that significant assurance can be given that there is a generally sound system of internal control, designed to meet the Trust's objectives, and that controls are generally being applied consistently.
- The external auditors did not provide non-audit services.

The main source of income for the Trust is the provision of healthcare services to the public under contracts with NHS commissioners. The Trust participates in the national agreement of balances exercise performed at months nine and twelve. The agreement of balances exercise identifies mismatches between receivable and payable balances recognised by the Trust and its commissioners and all differences are investigated by the finance team. The Trust also receives a material amount of other operating income for services such as education and training and Sustainability and Transformation funding from NHS Improvement. Given the materiality in value and the judgment used in relation to areas such as accruals for services not yet invoiced and partially completed spells, NHS and non NHS income has been identified as a risk in 2017/18.

Trusts are responsible for ensuring that the valuation of their property, plant and equipment is correct and for conducting impairment reviews that confirm the condition of these assets. As a result of the suggested accounting policies provided by NHS Improvement, trusts typically achieve this by performing an annual review for impairment, a periodic desk top valuation every three years and a full valuation in not more than five yearly intervals. The Trust undertook a desktop valuation and impairment review during 2017/18.

	Part of schedule A (see above)	Relating to	Code of Governance reference	Summary of requirement
20.	2: Disclose	Board/ Remuneration Committee	D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.
Not applicable.				
21.	2: Disclose	Board	E.1.5	The Board of Directors should state in the annual report the steps they have taken to ensure that the members of the Board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the Council of Governors, direct face-to-face contact, surveys of members' opinions and consultations.

The board of directors uses a variety of methods to understand the views of governors:
• The lead governor attends all meetings of the board of directors in full (including seminars, workshops and meeting sessions held in private) and is an active participant. This role 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 2017/18 council meeting agendas continued to be refined to provide more opportunities for non-executive directors to report to the council and for dialogue between non-executive directors and governors generally.
• The board invites a governor representative to attend meetings of its sub-committees to participate and feedback to governor colleagues. As the sub-committees are chaired by non-executive directors this facility gives more governors the opportunity to observe non-executive directors performing their duties as well as providing governors with wider insight into the operational activities of the Trust and corporate governance.
• The board of directors and council of governors have in place a document formalising principles of engagement between the council's governor representatives and the Trust's board-level structures and mechanisms.
• QVH's governor representative roles foster closer working relationships between governors and non-executive directors and provide more opportuni ties for governors to see NEDs at work on a regular basis. As a result, governors are better able to appraise the performance of the NEDs and hold them to account and NEDs are better informed of the views of governors and members. At its meeting on 15 January, the council of governors undertook a review of collective performance with particular reference to
  • holding the non-executive directors individually and collectively to account for the performance of the board of directors,
  • communicating with their member constituencies and the public and transmitting their views to the board of directors and
  • contributing to the development of forward plans of NHS Foundation Trusts.				

22.	2: Disclose	Board/ Membership	E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.
The board recognises the challenges and limitations of establishing a representative membership base as it serves a large regional population with a range of specialist services and a smaller local population with a range of community services. Nonetheless, it ensures it continues to meet its responsibility to engage with stakeholders through various means, including the regular scrutiny of Friends and Family Test and patient experience results. A QVH patient is invited to nearly every board meeting to describe their experience of care at the Trust. The Governor Representative roles continues to enable strong and direct engagement between governors and the board, especially NEDs.				
23.	2: Disclose	Membership	E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.
Members who wish to communicate with the directors or governors should contact the deputy company secretary on 01342 414200 or **hilary.saunders1@nhs.net** This information is also available from the Trust's website at: **www.qvh.nhs.uk/board-of-directors** and **www.qvh.nhs.uk/council-of-governors-2**				

	Part of schedule A (see above)	Relating to	Code of Governance reference	Summary of requirement
24.	Additional requirement of FT ARM	Membership	n/a	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.
The Trust's members belong to either the public or staff constitu ency. Paragraphs 8 and 9 of the Trust's constitution set out eligibility criteria for membership of each constituency. As at 31 March 2017, the number of members within the public constituency was 7,410 and the staff constituency was 916. The Trust's membership strategy was reviewed by the Trust and presented to members, governors and non-executive directors at the Trust's annual membership meeting on 31 July 2017. Additional information regarding membership of the QVH Foundation Trust can be found online at **http://www.qvh.nhs.uk/for-members/**				
25.	Additional requirement of FT ARM (based on FReM requirement)	Board/Council of Governors	n/a	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report. See also ARM paragraph 2.22 as directors' report requirement.
A register of directors' and governors' interest is kept by the Trust and is available on request from the deputy company sec retary.				
26.	6: Comply or explain	Board	A.1.4	The Board should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery.
Compliant.				
27.	6: Comply or explain	Board	A.1.5	The Board should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance.
Compliant.				
28.	6: Comply or explain	Board	A.1.6	The board should report on its approach to clinical governance.
The Trust's clinical governance group is responsible for: • Ensuring that QVH meets its statutory duty of quality through clinical governance. • Ensuring the best use of available resources for patients by establishing policies for effective clinical services. • Identifying and instigating policy improvement from clinical audit and outcomes monitoring processes. • Identifying and mitigating risks relating to the development and implementation of clinical policy. The group meets formally monthly and reports to the quality and governance 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, the Head of Risk, the governance leads of clinical specialties, senior nurses and service managers.				
29.	6: Comply or explain	Board	A.1.7	The chief executive as the accounting officer should follow the procedure set out by NHS Improvement (Monitor) for advising the Board and the Council and for recording and submitting objections to decisions.
Compliant.				

	Part of schedule A (see above)	Relating to	Code of Governance reference	Summary of requirement
30.	6: Comply or explain	Board	A.1.8	The Board should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life
Compliant. The constitution is reviewed periodically and published to the Trust's website; The Trust's Standards of business conduct and behaviour policy was revised in 2017/18 to reflect the national guidance on managing conflicts of interest in the NHS introduced in June 2017. The policy was approved by the Trust's Audit committee and subsequently disseminated to all members of staff. Details of thi s policy were also communicated to the council of governors at its meeting on 16 October 2017.				
31.	6: Comply or explain	Board	A.1.9	The Board should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility.
See 30 above.				
32.	6: Comply or explain	Board	A.1.10	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors.
Compliant.				
33.	6: Comply or explain	Chair	A.3.1	The chairperson should, on appointment by the council, meet the independence criteria set out in B.1.1. A chief executive should not go on to be the chairperson of the same NHS foundation trust.
Compliant: In January 2018, the council of governors approved the recommendation of its Appointments committee that the current Chair be appointed for a second term from 1 April 2018, having satisfied itself that this appointment met the criteria set out in B.1.1				
34.	6: Comply or explain	Board	A.4.1	In consultation with the Council, the Board should appoint one of the independent non-executive directors to be the senior independent director.
Compliant. In consultation with the council of governors, John Thornton was appointed as the Trust's senior independent director in September 2017.				
35.	6: Comply or explain	Board	A.4.2	The chairperson should hold meetings with the non-executive directors without the executives present.
Compliant. The Chair has met on alternate months with the non-executive directors throughout the course of 2017/18.				
36.	6: Comply or explain	Board	A.4.3	Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the Board minutes.
Not applicable in 2017/18.				
37.	6: Comply or explain	Council of Governors	A.5.1	The Council of Governors should meet sufficiently regularly to discharge its duties.
Compliant. The Trust's constitution stipulates that the council of governors should meet at least four times per year. During 2017/18 the council of governors held meetings in public on 10 April 2017, 31 July 2017, 16 October 2017, and 15 January 2018.				
38.	6: Comply or explain	Council of Governors	A.5.2	The Council of Governors should not be so large as to be unwieldy.
Compliant: The council of governors comprises 20 public members, three staff members and three stakeholder representatives, as established by paragraph 14 of the Trust's constitution.				
39.	6: Comply or explain	Council of Governors	A.5.4	The roles and responsibilities of the council of governors should be set out in a written document.
Compliant. NHS Improvement (Monitor) publishes guides to the duties and legal obligations of foundation trust governors for governors. General duties of the Trust's council of governors are included in provision 19 of the Trust's constitution.				
40.	6: Comply or explain	Council of Governors	A.5.5	The chairperson is responsible for leadership of both the Board and the Council but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive to their meetings and inviting attendance by other executives and non-executives, as appropriate.
Compliant. Provision 20 of the Trust's constitution explains the arrangements in place for the Trust.				
41.	6: Comply or explain	Council of Governors	A.5.6	The Council should establish a policy for engagement with the Board of Directors for those circumstances when they have concerns.
Provision 52 of the Trust's constitution sets out provisions for disputes between the council of governors and board of directors.				

	Part of schedule A (see above)	Relating to	Code of Governance reference	Summary of requirement
42.	6: Comply or explain	Council of Governors	A.5.7	The council should ensure its interaction and relationship with the Board of directors is appropriate and effective.
The council of governors relies on several roles and functions to ensure its interaction and relationship with the board of directors is appropriate and effective. These include: the role of the Trust chair as chairperson of both bodies; the role of the deputy company secretary as adviser to both bodies; the work of the governor steering group and appointments committee; and the role of the governor representatives to the board of directors and its sub-committees. QVH has a long-standing practice of inviting a representative (recommended by the council of governors and approved by the chair), to join the board as an ex officio, non-voting member. Some years ago the practice was extended to establish governor representatives to the main, non- statutory sub-committees of the board. These representatives are usually elected to the role by the council of governors. The role of governor representatives is appreciated by the Trust as an established and effective means of open and honest engagement between governors and the board. Since the Health and Social Care Act 2012, the governor representative roles have become par ticularly significant as they play an important part in governors' duty to hold non-executive directors (NEDs) to account for the performance of the board. The roles foster closer working relationships between governors and NEDs and provide more opportunities for governors to see NEDs at work on a regular basis. As a result, governors are better able to appraise the performance of the NEDs and hold them to account. The board of directors and council of governors have agreed a document formalising principles of engagement between the council's governor representatives and the Trust's board-level structures and mechanisms.				
43.	6: Comply or explain	Council of Governors	A.5.8	The Council should only exercise its power to remove the chairperson or any nonexecutive directors after exhausting all means of engagement with the board.
Not applicable in 2016/17. Paragraph 35 of the Trust's constitution describes the process for removal of the chair and other non-executive directors.				
44.	6: Comply or explain	Council of Governors	A.5.9	The Council should receive and consider other appropriate information required to enable it to discharge its duties.
Compliant.				
45.	6: Comply or explain	Board	B.1.2	At least half the Board, excluding the chairperson, should comprise non-executive directors determined by the Board to be independent.
Since September 2017, the board of directors has comprised the Chair, four other non-executive directors, a chief executive and three other (voting) executive directors. Gary Needle joined the board of directors as non-executive director in July 2017 and Kevin Gould joined as non-executive director in September 2017. In the case of equality of votes at a meeting of the board of directors, the Trust's constitution (provision 39.5) states that the Chair shall have the casting vote; although in 2017/18, the board was not required to vote on any matter of business.				
46.	6: Comply or explain	Board/Council of Governors	B.1.3	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust.
Compliant. See provision 18 of the Trust's constitution.				
47.	6: Comply or explain	Nomination Committee(s)	B.2.1	The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors.
Compliant. See 51 below.				
48.	6: Comply or explain	Board/Council of Governors	B.2.2	Directors on the Board of Directors and governors on the Council should meet the "fit and proper" persons test described in the provider licence.
The Trust's declaration of interests pro-forma for directors and governors also incorporates a fit and proper persons declaration. Declarations are made by all directors and governors accordingly with each submitting a self-assessment against the categories of person prevented from holding office.				
49.	6: Comply or explain	Nomination Committee(s)	B.2.3	The nominations committee(s) should regularly review the structure, size and composition of the Board and make recommendations for changes where appropriate.
Compliant.				
50.	6: Comply or explain	Nomination Committee(s)	B.2.4	The chairperson or an independent non-executive director should chair the nominations committee(s).
Compliant.				
51.	6: Comply or explain	Nomination Committee(s)/ Council of Governors	B.2.5	The governors should agree with the nominations committee a clear process for the nomination of a new chairperson and non-executive directors.

	Part of schedule A (see above)	Relating to	Code of Governance reference	Summary of requirement
The appointments committee is a sub-committee of the council of governors. Part of its remit is to oversee the appointment processes for the chair and non-executive directors, making recommendations in this regard to the council of governors. In 2017/18, a search for a non-executive director was initiated on behalf of governors by its Appointments committee with the support of the Trust's workforce director and corporate affairs team. The candidate brief was developed in collaboration with the Appointments committee, and was informed by a skills audit of existing non- executive directors undertaken by the Trust chair. The search, selection and nomination process was undertaken by the Appointments committee on behalf of the council of governors. This appointment was formally ratified in public at the council of governors meeting on 31 July 2017 Also in 2017/18, noting that the current Chair would be coming to the end of her first term in March 2018, the Appointments committee met to consider re-appointing her for a second term. Having satisfied itself that all necessary criteria had been met, the Committee recommended to the council that Beryl Hobson be re-appointed for a second term from 1 April 2018. This recommendation was approved by the council of governors at its meeting on 15 January 2018.				
52.	6: Comply or explain	Nomination Committee(s)	B.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist of a majority of governors.
Compliant.				
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 2017, a skills audit of existing non-executive directors was undertaken by the chair to map skills to the Trust's key strategic objectives and identify gaps. The results of the audit were used to develop and agree the candidate brief for the recruitment of a new non-executive director (see 51 above).				
54.	6: Comply or explain	Council of Governors	B.2.8	The annual report should describe the process followed by the Council in relation to appointments of the chairperson and non-executive directors.
See row 51 above.				
55.	6: Comply or explain	Nomination Committee(s)	B.2.9	An independent external adviser should not be a member of or have a vote on the nominations committee(s).
Compliant.				
56.	6: Comply or explain	Board	B.3.3	The Board should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity.
Not applicable.				
57.	6: Comply or explain	Board/Council of Governors	B.5.1	The Board and the Governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make.
Compliant. Papers for meetings of the board of directors and council of governors are available from the Trust's website. In addition to meeting papers, the board of directors and council of governors receive regular briefings from the Trust, its regulators and its representative bodies to inform and provide context to the functions and decisions of the board and the council. The council of governors receives notification when papers for meetings of the board of directors are published and the meeting agenda and chief executive's report are extracted from the papers and issued directly to governors. Governors have a facility to log general queries to non-executive directors and the Trust's executive management team. The log records the response to the queries so that they can be shared systematically with all governors to share information and learning across the council. Governor representatives to the board and its sub-committees also submit personal reports to their colleagues in the company secretarial team's monthly newsletter for governors.				
58.	6: Comply or explain	Board	B.5.2	The Board and in particular non-executive directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the Board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis.
Compliant.				

	Part of schedule A (see above)	Relating to	Code of Governance reference	Summary of requirement
59.	6: Comply or explain	Board	B.5.3	The Board should ensure that directors, especially non- executive directors, have access to the independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors.
Compliant.				
60.	6: Comply or explain	Board/ Committees	B.5.4	Committees should be provided with sufficient resources to undertake their duties.
Compliant.				
61.	6: Comply or explain	Chair	B.6.3	The senior independent director should lead the performance evaluation of the chairperson.
The performance of the chair is assessed by the senior independent director in collaboration with the chair of the council of governors' Appointments committee and taking into account feedback sought from non-executive directors, executive directors and governors. See row 13 above.				
62.	6: Comply or explain	Chair	B.6.4	The chairperson, with assistance of the Board secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as board members.
Compliant. The board of directors meet every other month for a seminar which gives a greater focus on strategy development and opportunities for board development. The board development programme has been shaped to ensure that it operates ef fectively and that the organisation is well led. The programme is the responsibility of the Trust chair who is supported in this task by the dir ector of workforce and organisational development and the director of communications. At its meeting in January 2018, the board considered the approach taken to date, and discussed priorities for board development in the coming year.				
63.	6: Comply or explain	Chair/Council of Governors	B.6.5	Led by the chairperson, the Council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities.
The collective performance of the council was reviewed at its meeting on15 January 2018. The report supporting this review is available online at **www.qvh.nhs.uk/public-meetings** Communication with members and the public on how the council has discharged its responsibilities is also 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.
Compliant. The circumstances in which a governor may be disqualified or removed from the council of are set out in provision 18 of the Trust's constitution.				
65.	6: Comply or explain	Board/ Remuneration Committee	B.8.1	The remuneration committee should not agree to an executive member of the Board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the Board first having completed and approved a full risk assessment.
Not applicable.				
66.	6: Comply or explain	Board	C.1.2	The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary. See also ARM paragraph 2.12.
See section 2.1.				

	Part of schedule A (see above)	Relating to	Code of Governance reference	Summary of requirement
67.	6: Comply or explain	Board	C.1.3	At least annually and in a timely manner, the Board should set out clearly its financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance.
Compliant. The board sets out clearly its financial quality and operating objectives for the Trust through board papers, published to the website. These include both quantitative and qualitative information on the Trust's business and operation. Clinical outcome data is included in the annual quality account.				
68.	6: Comply or explain	Board	C.1.4	a) The Board of Directors must notify NHS Improvement and the Council of governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS foundation trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS foundation trust. b) The Board of Directors must notify NHS Improvement and the Council of Governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in: • the NHS foundation trust's financial condition; • the performance of its business; and/or • the NHS foundation trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS foundation trust.
Compliant.				
69.	6: Comply or explain	Board/Audit Committee	C.3.1	The Board should establish an audit committee composed of at least three members who are all independent non-executive directors.
Compliant.				
70.	6: Comply or explain	Council of Governors/Audit Committee	C.3.3	The Council should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors.
Compliant.				
71.	6: Comply or explain	Council of Governors/Audit Committee	C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust.
Compliant: The Trust's external auditor was originally appointed in August 2011, and following a transparent and competitive process was reappointed in October 2016 for a period of three years, with an option to extend for a further two years.				
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 NHS Improvement informing it of the reasons behind the decision.
Not applicable.				

	Part of schedule A (see above)	Relating to	Code of Governance reference	Summary of requirement
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 2017/18, Mazars acted as providers of the Trust's local counter fraud specialist service. An annual work plan was agreed and delivery was overseen by the audit committee. Counter fraud policies and procedures are widely publicised for staff and are included as part of the new staff induction process. Whistleblowing is the responsibility of the quality and governance committee. However, the audit committee is responsible for providing assurance that the whistleblowing process is fit for purpose and working effectively, as required by the board. A freedom to speak up guardian was elected by staff in April 2017. This role is specifically aimed at staff, and provides confident ial advice and support in relation to concerns about patient safety. The role reports directly to the chief executive and attends t he board of directors quarterly to report on findings.				
74.	6: Comply or explain	Remuneration Committee	D.1.1	Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels.
Compliant.				
75.	6: Comply or explain	Remuneration Committee	D.1.2	Levels of remuneration for the chairperson and other non-executive directors should reflect the time commitment and responsibilities of their roles.
Compliant. The council of governors appointments committee undertakes an annual review ensuring that QVH remuneration is as close to national median benchmarks as possible, whilst ensuring it is sufficient to attract, retain and motivate non-executive directors with the skills and experience needed to lead the Trust successfully.				
76.	6: Comply or explain	Remuneration Committee	D.1.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination.
Not applicable.				
77.	6: Comply or explain	Remuneration Committee	D.2.2	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments.
Compliant.				
78.	6: Comply or explain	Council of Governors/ Remuneration Committee	D.2.3	The Council should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.
Compliant. Following publication of the 2016 remuneration survey by NHS Providers, the Appointments' Committee reviewed the remuneration and terms and conditions of the Chair and non-executive directors, and made recommendations in this regard to the council of governors at its public meeting on 30 July 2017.				
79.	6: Comply or explain	Board	E.1.2	The Board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums.
Compliant.				
80.	6: Comply or explain	Board	E.1.3	The chairperson should ensure that the views of governors and members are communicated to the board as a whole.
Compliant. Responsibility for ensuring that the views of governors and members are communicated to the board as a whole is shared between the chair, the Director of Communications and Corporate Affairs and the Lead Governor.				

	Part of schedule A (see above)	Relating to	Code of Governance reference	Summary of requirement
81.	6: Comply or explain	Board	E.2.1	The Board should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co- operate.
Compliant: The board of directors recognises that co-operation and collaboration are key to the sustainability of the organisation. Over the last year the board has considered and continued to develop its relationships third parties including: • The Sussex and East Surrey STP, with executive directors and the Trust chair regularly participating in all of the associated working groups and meetings • The Kent and Medway STP, with links made at chief executive level • NHS trusts which host QVH 'spoke' services across the South East Region • Brighton and Sussex University Hospitals Trust, with specific work on the Memorandum of Understanding providing a framework for sustainable specialist and tertiary healthcare services for the populations currently served by BSUH and QVH				
82.	6: Comply or explain	Board	E.2.2	The Board should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each.
Compliant. See row 81.				

"Our quality priorities are built around our ambitions to deliver safe, reliable and compassionate care in a transparent and measurable way"

3.5 NHS Single Oversight Framework

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

looks at five themes:

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

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

Segmentation

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

This segmentation information is the Trust's position as at 9 May 2018. Up to date segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust shown above may not be the same as the overall finance score. The table below details the use of resources score in 2017/18.

Area	Metric	2017/18 Q1	2017/18 Q2	2017/18 Q3	2017/18 Q4
Financial sustainability	Capital service capacity	2	1	2	1
	Liquidity	1	1	1	1
Financial efficiency	Income and expenditure margin	1	1	1	1
Financial controls	Distance from financial plan	1	1	1	1
	Agency spend	1	2	2	2
Overall scoring		**1**	**1**	**1**	**1**

The Trust's overall score is 1; the highest score possible. A score of 1 was also achieved in four out of the five individual metrics with the single exception being performance on agency spend. This metric measures performance against an agency spend target, as set by NHS Improvement. The Trust was unable to achieve the target due to recruitment issues in areas of national shortage, the requirement for increased capacity and to deliver performance targets.

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

The National Health Service Act 2006 (NHS Act 2006) states that the chief executive isthe accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Queen Victoria Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Queen Victoria Hospital NHS Foundation Trust and of its income and expenditure, items of other comprehensive income and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- assess the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and 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. The accounting officer is also responsible for ensuring that the use of public funds complies with the relevant legislation, delegated authorities and guidance.

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

Steve Jenkin

Chief Executive and Accounting Officer

24 May 2018

3.7 Annual governance statement

Scope of responsibility

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

The purpose of the system of internal control

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

The system of internal control has been in place in Queen Victoria Hospital NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The board views risk management as a corporate responsibility, in line with the NHS Improvement 2017 Well Led Framework which requires the board to have effective systems and processes in place to mitigate and manage risk. The board is committed to the continuous development of a risk management framework focused on preventing harm to patients, staff and the public and to protect the Trust from losses or damage to its reputation.

The director of nursing is the Trust's lead for risk, supported by the head of patient safety. The Trust's quality and governance committee has delegated authority from the board to provide assurance that effective systems and processes are in place for optimum risk management. The clinical governance group is responsible for the management and monitoring of risk management in the organisation. The quality and governance committee is chaired by a non-executive director. At every public board meeting there is a detailed quality report which incorporates risk management and a report from the chair of the quality and governance committee to provide assurance about the risk management within the organisation.

The board assurance framework and the corporate risk register are also reviewed in full at every public board meeting to provide each board member the opportunity to seek assurance about the level of risk, mitigating actions and gaps in controls to sustain and improve performance against fundamental standards of quality and safety. The board assurance framework details the risks to achieving the organisation's five key strategic objectives.

At year end the corporate risk register included three risks which the Trust considered to remain at a significant level despite mitigating actions. These related to the Trust's ability to meet the national 18 week referral to treatment target, the related issue of a need to improve staffing, systems and processes in the appointments team, and the risk that although the Trust would make a financial surplus in 2017/18 this may not be as large as that agreed with NHS Improvement at the beginning of the year. Mitigating actions included recruitment of additional staff in roles related to managing the waiting list and delivery of staff training; advice on systems and processes from the NHS Improvement intensive support team; and identifying alternative providers for some patients. The Trust has plans in place for 2018/19 to make sure patients are treated in a timely manner and to ensure continued robust financial management.

The well-led review demonstrated that management of risk has a high profile in the organisation with effective escalation of concerns and focus on controls. The Trust plans to further strengthen reporting to support strategic discussion of risk.

The risk and control framework

The current Trust risk management strategy covers the four year period to 2020. The strategy outlines the framework within the Trust governance structure and the requirements for individuals and teams to comply with key regulatory instructions and legislation, to manage risk effectively and contribute to achieving the Trust's key strategic objectives.

The Trust's risk management and incident reporting

policy provides an outline of the risk processes and the ways in which a risk should be assessed, actioned and escalated. It also defines the difference between incidents and risks. The Trust's risk assessment tool includes a matrix to determine the level of risk based on likelihood and consequence. It requires the assessor to identify hazards, existing controls and further controls required. All staff complete mandatory risk training to ensure they are equipped to navigate the incident reporting system (Datix). Incidents can be logged directly by the individual on the Trust reporting system or via their line manager. A risk can be raised by the individual speaking to their line manager or risk manager. There is also provision for staff to raise a risk confidentially or anonymously to the director of nursing using an anonymous 'Tell Jo' email account, contacting the Trust's Freedom to Speak Up Guardian or using the Trust's whistleblowing process.

Once a potential risk is identified, the individual or team are supported by the risk team in a wider triangulation of information such as previous incidents, audits, external reviews, complaints and quality metrics to determine if this is an actual risk. If this is the case the risk is scored and appropriate actions and mitigations identified and the risk is added to department (local) or corporate risk register. Departmental risks are managed by the clinical lead and / or manager within the department to ensure staff are aware of potential hazards within their working practice and that mitigating actions are in place. If a risk score is 12 or more the risk is added to the corporate risk register. The risk registers are all reviewed monthly; the departmental risk registers at governance and business meeting and the corporate risk register by the executive management team and the quality and governance committee.

Each of the corporate risks has a lead director responsible for reviewing the risk with the Trust directors, monthly using the risk assessment matrix and then at the board committees and public board detailing the controls or gaps in control which mitigate the risk fully or partially. Risks on both the corporate and local registers are reviewed and managed with re-scoring or closing of the risk, whichever is appropriate.

The Trust's risk management and incident reporting policy is published on the Trust intranet. Staff receive induction and mandatory training and, where required, bespoke training to facilitate risk management knowledge at all levels across the Trust.

From March 2018 new incident investigation training sessions are being implemented for staff, introducing a structured way in which to undertake investigations and produce detailed, high quality reports as required for both internal and external distribution.

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

Identified learning from incident investigations is incorporated within reports and presentations tabled at a variety of forums across the Trust. The most significant learning during the year was from attending the coroner's court. The learning from this has been shared widely throughout the Trust and also presented externally to our commissioners and regulators and at a safety collaborative conference. In addition to this, all serious incident action plans are reviewed at the clinical governance group one year after the incident for assurance that the actions completed are fully implemented and embedded in practice.

A range of data and risks are managed via the Trust risk management software package, these include, 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 and this information is shared with the business units each month forming part of the governance and risk management agenda.

The Trust's risk appetite is based on the board's willingness to expose itself to risk in order to achieve its strategic objectives. The level of autonomy a manager or group or committee has in managing risk contributes to the risk appetite. High-level risks (major and catastrophic rated 12-25) are escalated to the clinical governance group, quality and governance committee and board. If adequate controls cannot be put in place to treat the risk a decision will be made to transfer or accept the risk.

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

- The public Trust board meetings are held bimonthly, there are detailed reports which include all key national performance measures on quality, operational performance, finance and workforce. There is opportunity for robust challenge and debate about these reports and the way in which the directors work collaboratively in order to meet the Trust's key strategic objectives and provide leadership and oversight of the systems in place for care provision and service delivery. In addition to this governance process, the non-executive chair of each board committee presents a report to the board about the level of assurance and key items for approval or discussion. All actions are monitored via a board action log.
- The quality and governance committee and the finance and performance committee are sub committees of the board. Directors present detailed reports on quality, operational performance, finance and human resources and there is an opportunity for scrutiny and challenge of these reports prior to them being presented at public board. Both committees monitor completion of actions via a committee action log.
- The audit committee seeks additional assurance on risk management by commissioning internal and external audits as part of the audit work programme or in response to specific issues and requires evidence that effective systems and processes are in place to mitigate and manage risk.
- The board assurance framework and corporate risk register are discussed at every public board meeting.
- Timely response to NHS Improvement information and monitoring requests and executive management team attendance at the quarterly NHS Improvement performance reviews.
- Quarterly engagement meetings with the Care Quality Commission (CQC) to enable CQC to monitor our performance and actions taken to support quality improvement. This allows CQC to discharge its formal regulatory duty through informed discussion with providers.

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

Risk management is embedded throughout the organisation, for example, risk management is included within each departmental meeting agenda and existing risks are discussed along with the identification of new risks. Staff are actively encouraged to report incidents and near misses to identify potential risks and take action to prevent this. Learning from incidents is integral to the risk process and is shared at a variety of forums and groups including the clinical governance group, quality and governance committee, the weekly staff newsletter and the joint hospital governance group. During 2017/18 we have undertaken significant work in theatres to reduce risk and develop a theatre safety culture and in addition to these measures we have appointed a new theatre safety lead nurse. We are currently investing in a simulation faculty to further improve training and the ways in which we learn from adverse events and the impact human factors has on this.

The clinical governance group monitors all clinical incidents to ensure actions identified are completed and learning is shared. The quality and governance committee seeks assurance that the systems and processes in place to monitor quality and safety are robust. Examples of changes as a result of the learning in 2017/18 include all serious incident reports being reviewed in full by the quality and governance committee, all action plans relating to these incidents are also now reviewed one year on to assess if the changes have become embedded in practice, new serious investigator incident training has been developed and the first cohort of staff has just completed this, as well as bespoke training sessions and amendments to Trust policies.

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

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

The effectiveness of emergency planning and business continuity systems are assured through a number of mechanisms including table top exercises and lockdown drills, partnership working with commissioners and NHS England, and peer review by the Local Health Resilience Partnership. The Trust has carried out the

required national self-assessment which has been reported to the board. There are 66 core standards and QVH was compliant in 59, giving the Trust a compliance rating of 'partial'. Actions resulting from this assessment included identifying a nonexecutive director who formally holds the emergency planning and resilience portfolio for the organisation, ensuring all on call managers maintain a continuous personal development portfolio demonstrating training, and updating documentation around emergency supplies of fuel in the event of shortage.

In 2017/18 there were two 'deep dives', one on the emergency planning governance arrangements of the Trust and one for the burns unit as part of the burns network arrangements.

Queen Victoria Hospital is fully compliant with the registration requirements of the Care Quality Commission (CQC) following a full inspection in November 2015.

Review of economy, efficiency and effectiveness of the use of resources The Trust ensures economy, efficiency and effectiveness in a number of ways including robust planning, application of controls, performance monitoring and independent reviews.

The financial plan for 2017/18 was approved by the board and submitted to NHS Improvement as required. Performance against the plan, any variations and remedial actions are examined at executive-led performance reviews and at an executive management meeting for oversight and scrutiny. Furthermore, reports including forecast projections, performance indicators and supporting narrative are presented at a monthly finance and performance committee and bi-monthly to the Trust board for assurance purposes.

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

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

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

During 2017/18, the Trust has performed well against the internal cost improvement and productivity challenge; meeting expectations. In response to the challenge to deliver year-on-year improvements, the Trust has invested in a programme management office in 2016/17. This team is now embedding within the Trust and is functionally responsible for driving the end-to-end process of identification, implementation and evaluation of cost improvement, productivity and business development initiatives across the Trust. Further work in 2018/19 will focus on demand and capacity and theatre utilisation in additional to the continued development of improvements.

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

Information governance

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

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

One of the key responsibilities of the information governance group is to oversee the Trust's annual information governance toolkit assessment. The toolkit is an online system which allows NHS organisations to assess themselves against relevant policies and standards. The information governance agenda is constantly evolving.

During 2017/18, priority has been given to cyber security and in particular addressing any threats to our

systems, processes and data. Intelligence has been used to create an action plan which includes ensuring all staff and volunteers are formally trained and tested on their understanding of the importance of handling data securely.

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

There were no serious incidents that were classified as a level 2 relating to information governance in 2017/18.

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. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The draft report has been circulated by the Trust to internal and external stakeholders to ensure that the data and information in the report is recognised and provides an accurate reflection of the quality and quality assurance processes at QVH. The systems and processes described in the care quality, enhanced quality governance and capacity to handle risk sections demonstrate that there are appropriate controls in place for the organisation to have a balanced view on quality.

In response to the limited assurance opinion from last year's quality report, the Trust prioritised the appointment of a patient access and performance manager to lead a review and redesign of 18-week referral to treatment and 62-day cancer waits.

We are currently working with NHS Improvement on our access pathways and work is in progress to redesign both the 18-week and cancer patient tracking list, refresh systems and processes to track and validate patients and refresh the training offered to staff.

The issue of data quality at our spoke sites remains a challenge for QVH. Work is underway to improve the quality of all externally supplied data. Whilst we are confident that this will lead to a significant improvement in data quality, the absence of a full year's data will result in the external auditors being unable to give QVH an unqualified opinion for 2017/18.

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

- Quarterly updates to the quality and governance committee on progress against quality priorities chosen for the quality account 2017/18
- Members of the clinical governance group, committees of the board and hospital management team receive performance reports on quality and performance metrics including infection control rates, referral to treatment performance, cancer waits, and patient experience measures
- National statutory data collected from external sources, which enables benchmarking and comparison with peers
- Specialty data compiled in conjunction with clinical directors and lead clinicians
- Specialty information/audit and national audit outcome data received by the clinical governance group
- External audit commissioned before submission to ensure data accuracy and validity.

Review of effectiveness

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

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

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

Conclusion

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

Steve Jenkin

Chief Executive

24 May 2018

4 Quality Report 2017/18

"Our participation in research is one of many areas where we make a contribution to the wider NHS greater than expected for a trust of our size"

Statement on quality

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

Our participation in research is one of many areas where we make a contribution to the wider NHS which is greater than expected for a trust our size. Our involvement in research helps us to attract the best clinical staff, supports our teams in staying abreast of the latest treatment possibilities and enables us to deliver the very best care for our patients.

From electrochemotherapy for head and neck cancer patients to the treatment of professional drivers with sleep disordered breathing, and from minimally invasive glaucoma surgeries to cranial nerve surgery for people at risk of blindness due to numb corneas, QVH continues to pioneer services for patients which are not available elsewhere in the south east.

QVH is an outward looking organisation. We participate in national and international conferences to learn and to share expertise, and we work in strong partnerships closer to home across Sussex and into Kent and Surrey. Our staff are rightly proud of the amazing work that happens at QVH and are passionate about further improving our services for patients.

This quality report sets out in detail our commitment to continuous, evidence-based quality improvement, the progress we have made over the last year and our plans for the coming year. I am confident that in 2018/19 QVH will continue to provide high quality, safe and effective services, and that our approach to quality will remain that we deliver excellence in all that we do.

Steve Jenkin
Chief Executive
24 May 2018

Priorities for improvement and statements of assurance from the board

QVH's quality priorities for 2018/19

Our quality priorities for 2018/19 are built around our ambitions to deliver safe, reliable and compassionate care in a transparent and measurable way. They have been developed in collaboration with staff and the council of governors, and take into account progress on our 2017/18 priorities and patient feedback.

Each priority comes under one of the three core areas of quality:

Patient safety

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

Clinical effectiveness

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

Patient experience

Meeting our patients' emotional as well as physical needs.

Progress against these priorities will be monitored by the Trust's quality and governance committee on a bi-monthly basis. Progress will also be reported at board meetings.

Priorities for improvement 2018/19

Our quality priorities and why we chose them	What success will look like
Patient safety	
Measurement of compliance with the WHO Surgical Safety checklist Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. During 2017/18 QVH had three Never Events. The Trust continues to report and investigate all Never Events which have occurred on site. June 2008: World Health Organisation (WHO) launched a global patient safety challenge and safety checklist. The National Patient Safety Agency adapted the WHO Surgical Safety Checklist in January 2009 and QVH was required to implement the checklist by February 2010. QVH relaunched the WHO checklist in 2018 including bringing into QVH practice learning from a London teaching hospital. A revised baseline qualitative audit was undertaken in March 2018 which identified a number of potential barriers to full compliance, including: • lack of engagement with the process; • distractions (such as staff performing other tasks whilst WHO checklist being completed); • inconsistent leadership between theatres in terms of who was responsible for sign in, time out and sign out. This baseline audit was supported by consultation events held within the theatres department to further identify the factors that have an impact on the successful implementation of this safety checklist and formulate actions to ensure the checklist can be embedded.	QVH will have no Never Events in 2018/19. To support this, QVH will target a quarterly improvement or sustained compliance in observational audits within theatres. The Trust will identify and train faculty members and roll out multidisciplinary safer surgery simulation training. The audits detailed above will be measured against reviewed and updated surgical safety policies including Five Steps to Surgical Safety and the perioperative marking policies.

Our quality priorities and why we chose them	What success will look like
Clinical effectiveness	
Increased theatre productivity (continuation of 2017/18 priority over a two year period - previously the 2017/18 patient safety priority) QVH is a surgical hospital and our operating theatres are critical for treating and caring for our elective and trauma cases. Using our theatres efficiently and effectively is key to reducing waits for treatment, reducing cancellations and making best use of NHS money. It is also important for patient experience and staff morale.	While there will always be some operating lists where start time is delayed, for example if a clinician urgently needs to attend to a seriously unwell patient on the ward, the QVH target for elective lists starting within 15 minutes of the booked start time is: Q1 2018/19 60% Q2 2018/19 70% Q3 2018/19 75% Q4 2018/19 80% The start of an operation is defined as the moment when the anaesthetic is administered or needle to skin time. Data will be produced daily in relation to late start times and reasons, and we plan to show a quarterly decrease in late theatre starts on the theatre dashboard.
Patient experience	
Improved clinician communication and customer care expectations This indicator was selected as although the Trust receives only a small number of complaints a consistent theme in these over the last three years has been around clinician communication and customer care expectations.	As part of our organisational development strategy we will develop a toolkit of resources to support and enable our workforce (clinical and non-clinical) to deliver the values and behaviours of QVH. We will design a number of interventions and measure the effectiveness of these by undertaking pre and post intervention surveys of complaints and PALS contacts, specifically looking for a reduction in the number of negative references to communication. We will review the verbatim comments from the quarterly staff friends and family test.

Performance against 2017/18 quality priorities

Our quality priorities for 2017/18 were influenced by information from national and local reports and audit findings, along with the views of QVH governors, patient feedback and suggestions from staff across the organisation.

End of year progress against our three 2016/17 quality priorities was as follows:

Our quality priorities and why we chose them	Targeted outcome	Did we achieve it in 2017/18
Patient safety		
Increased theatre productivity QVH is a surgical hospital and our operating theatres are critical for treating and caring for our elective and trauma cases. Using our theatres efficiently and effectively is key to reducing waits for treatment, reducing cancellations and making best use of NHS money. It is also important for patient experience and staff morale.	The QVH target for elective lists starting within 15 minutes of the booked start time was: • Q1 70% • Q2 75% • Q3 80% • Q4 85% The start of an operation is defined as the moment when the anaesthetic is administered, or 'needle to skin' time.	This quality priority was moved to a two year programme within 2017/18 because the data collection methods were changed within year. Consequently further work needed to be undertaken to ensure data accuracy which was supported by a programme of staff training. In Q3 54% of our elective lists started within 15 minutes of the booked start time. In Q4 56% of our elective lists started within 15 minutes of the booked start time.
Clinical effectiveness		
Mouth Care Matters This is an initiative to improve the oral health of all of our inpatients. It was designed to raise awareness of the links between oral health and general health, and ensure that patients' mouth care is being looked after and recorded in the notes for all inpatients. The programme involved four audits. Audit 1 assessed whether mouth care is being recorded in patient notes. Audit 2 measured patient feedback on the current level of mouth care on our wards, to see if anything could be improved. Audit 3 was a written questionnaire undertaken every six months to seek the views of nursing staff on mouth care, including suggestions for improvements. Audit 4 was carried out quarterly to assess whether the newly implemented mouth care recording pack was being used and whether any improvements could be made.	Auditing will show mouth care being recorded in patient notes and improvements being made to our current oral health practice to the benefit of patients. There will be an increase in staff confidence in providing mouth care to our patients and understanding of the importance of good oral health in relation to the patient's general health. This will be measured through the nursing feedback questionnaire and training course evaluations.	This quality priority was achieved A quarterly increase in findings was shown in both audits 2 and 4 in all four quarters of 2017/18. Mouth care training sessions delivered to nursing assistants, nurses and other staff members involved in the provision of mouth care has raised awareness of mouth care and oral hygiene issues across QVH. An increased awareness enables staff members to deal with any patient mouth care issues more effectively and improve patient quality and experience. In addition, a range of new mouth care products have been introduced across the Trust to help treat different mouth conditions and to improve the oral hygiene of our patients, as it is recognised that oral hygiene can deteriorate during hospital stays.

Our quality priorities and why we chose them	Targeted outcome	Did we achieve it in 2017/18
Patient experience		
Improving patient experience in outpatients Last year patients attended 173,500 outpatient appointments at QVH and it is important to us that this should be a positive experience. We are continuing to work on initiatives that will make the waiting time shorter and each waiting area is being reviewed to ensure that when waits are unavoidable, patients are made as comfortable as possible and kept informed.	By the end of 2017/18 there will be designated paediatric waiting areas within outpatients, improved vending facilities and an improved waiting environment. We also aim to reduce waiting times in clinics, improve clinic utilisation and reduce the amount of rebooking of appointments due to hospital and patient cancellations.	Funding from charitable funds was gained to improve the current waiting areas for children in all outpatient areas by providing a designated area for children and their families when visiting the departments. New chairs including bariatric and high back chairs (for patients awaiting transport) were ordered for waiting areas within the main outpatients department. The Trust's positive friends and family test scores for outpatients who are extremely likely/likely to recommend QVH as a place to receive care and treatment can be found under the reporting of core national quality indicators later in this report.

Safe

Sign up to Safety campaign

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

There is a systematic approach to safety within QVH, with staff encouraged and supported to report safety issues via the Datix system. The previously introduced 'feedback' option on Datix whereby reporters can request details of the investigation findings is working well, at times resulting in challenges to the findings.

Investigation processes have been reviewed and new training for staff undertaking serious incident investigations commenced in March 2018.

Teams are working to share best practice around embedding learning from incident investigations.

Duty of Candour

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

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

The board is committed to openness and transparency at all levels across QVH, including being open and honest with patients and/or their relatives and carers. In 2017/18 we undertook a retrospective audit of the duty of candour process and identified areas which we could strengthen.

A number of initiatives have been implemented to ensure that we are effective in embedding the duty of candour into our systems and processes; including the introduction of a proforma to be completed by staff which guides them through what is required at each step of the process.

This, alongside training updates, ensures that the Trust maintains statutory compliance. All cases that have been graded as moderate or higher in 2017/18 have fully met the duty of candour statute.

Implementation of seven day hospital services

The seven day services programme is designed to ensure patients who are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital.

There are ten clinical standards, of which four have been identified nationally as priority on the basis of their potential to positively affect patient outcomes:

- Standard 2: time to consultant review – patients do not wait longer than 14 hours to initial consultant review
- Standard 5: diagnostics – ensure patients get access to diagnostic tests with a 24-hour turnaround time - for urgent requests, this drops to 12 hours and for critical patients, one hour
- Standard 6: consultant directed interventions – patients get access to specialist, consultant-directed interventions
- Standard 8: on-going review in high dependency areas – ensure that patients with high-dependency care needs receive twice-daily specialist consultant review, and those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds

QVH has an implementation plan in place to deliver the four priority clinical standards and continues to participate in the national bi-annual seven day services assessment which concentrates on clinical standard 2: time to consultant review. We review the findings of each assessment to identify any action needed to ensure that QVH is able to meet these standards for our patients. QVH continues to align services with national priorities to ensure the delivery of seven day hospital services.

Locally defined clinical standards have also been developed which group our admissions into those that should be reviewed by a consultant within 1 hour, those within 14 hours and those who could wait until 24 hours (i.e. the next morning trauma round). These clinical standards are now an integral part of QVH's operational trauma policy.

Safeguarding

At QVH we strive to maintain a continuous focus on our safeguarding duty of care as part of everyday safe clinical practice, and through staff learning and development. We do this to protect our most vulnerable patients whether they are children, young people or adults.

Legal frameworks, relevant policies and procedures are used to support safe practice. Safeguarding is a broad umbrella term which covers many areas that might be of concern. At QVH we try to hold these in mind as we work with our patients to keep them safe.

Safeguarding children

The principle that welfare of the child is paramount was enshrined in the Child Act 1989. It has driven the development of systems used to safeguard and protect children since that time. It has been strengthened by additional legislation being added into various other Acts since that time. Section 11 of the Children Act 2004 places a statutory duty on all NHS organisations to ensure that services are designed to safeguard and promote the welfare of children.

Safeguarding adults

Since its implementation, the Care Act 2014 has provided a legal framework by which NHS organisations working with other agencies can take steps to protect vulnerable adults when the need arises. QVH makes safeguarding personal by working closely with the adult for whom there are concerns identified.

Mental capacity act

The Mental Capacity Act 2005 became operational in 2007. Having mental capacity is the ability to make a particular decision or take a particular action at the time the decision needs to be made or the action taken. This means that vulnerable patients from the age of 16 years onwards are supported using mental capacity processes when required to make decisions regarding serious medical treatment.

QVH has recruited a dual trained, registered and mental health nurse to improve care for patients with mental health needs, who is supporting staff with practical advice and education.

Prevent

Health professionals meet and treat many children, young people and adults, some of whom might be vulnerable to radicalisation. Radicalisation is the processes by which people come to support violent extremism and in some cases join terrorist groups. In the NHS we try to identify those who are vulnerable to radicalisation and find the right support for them before anyone is persuaded to commit crimes.

Staff training and development

To enable staff to manage safeguarding, mental capacity and radicalisation issues safely and effectively the Trust has a rolling programme of internal, external and eLearning options. Internal training uptake is measured and reported to the board monthly.

	Adult safeguarding training uptake		
	Level 1	Level 2	Level 3
Adults	96%	89%	New for 2018. (30 staff at 31 March 2018)
Children	93%	89%	84%
Mental Capacity Act	96%	89%	New for 2018. (30 staff at 31 March 2018)
Prevent refresh training	93%	89%	73% (once only training)

"QVH has recruited a dual trained, registered and mental health nurse to improve care for patients with mental health needs."

QVH three year rolling safeguarding clinical audit programme

QVH has a safeguarding programme of audit which is used to support staff to review practice, reflect on care provided, identify opportunities to improve required skills and share learning.

Patient safety		
2016 NICE PH50 : Domestic violence and abuse: multi-agency working	Baseline assessment March 2016 Organisation audit started August 2016	Informed a review of policy and updates to training for staff. Identified resources to support families and staff when required.
2016 NICE CG89: Child maltreatment: when to suspect maltreatment in under 18s	Organisation audit started August 2016	Informed an update of staff training. Led to the production of leaflets for families to help them understand the way we work.
2017 Referrals audit – adults and children	December 2017	Undertaken annually to review the quality and content of the referrals we make to social care services across the region.
2017 CG89 and PH 50 SurveyMonkey for medical staff	January 2018	Used as a way to capture safeguarding understanding and knowledge of the medical and dental staff at QVH.
2017 Adults Mental Capacity Act knowledge audit	December 2017	Identified resources to support families and staff when mental capacity assessment and best interest decisions are required. Led to the production of leaflets for families to help them understand the way we work.
2017 Adults Mental Capacity Act compliance audit	December 2017	Informed review of Mental Capacity Act policy and updated training for staff.
2018 Referrals audit – adult and children	Due September to December 2018	To be completed during 2018.
2018 Safeguarding prompts card audit	Due September 2018	To be completed during 2018.
2018 Child not brought to appointment protocol audit	Due March 2018	To be completed during 2018.

Safeguarding activity

A mixture of activities are undertaken to help staff to support their vulnerable patients effectively and safely. QVH staff work hard to maintain relationships with children, young people, adults and their families when there are difficult questions or issues to explore.

We work in partnership with families and agencies to enable the right help and support to be put in place. QVH is a member of both the West Sussex Safeguarding Children Board and the West Sussex Safeguarding Adults Board.

Safeguarding achievements during 2017/18

Each year we have a number of new activities to enhance patient safety, and to keep patients and their families informed about decisions we might make or actions we might take.

Electronic Discharge Notification	Includes a safeguarding section.
Use of Datix system	To record and provide overview of safeguarding referrals and concerns, plus to demonstrate compliance with the Mental Capacity Act.
Supporting staff who report they are experiencing domestic violence and abuse	Staff policy now in place and support offered to staff who report they are experiencing domestic violence and abuse.
Better information for patients and their families	Development of a number of patient leaflets to help them understand situations in which they might find themselves.
Child Protection Information service	National system, rolled out for use at QVH.

Safety achievements

2017/18 achievements	Further work for 2018/19
Antibiotic levels in burn wounds – ABLE study Antibiotic resistance has made the news repeatedly and the chief medical officer has called it a global threat. The burns service is always interested in evaluating the care we provide to our patients. Sometimes we give antibiotics to patients but they do not work. At other times we may see wounds which appear to be infected but we wait for specific culture results to inform our choice of antibiotics, in the time taken for the results to come back from the lab the wound may have improved. The study takes samples of blood and wound fluid from patients to investigate their antibiotic levels. The burns service was successful in receiving a grant from the Hospital Saturday Fund which has enabled the study to be extended to other burns centres in the UK which will increase recruitment numbers and give us a clear understanding whether antibiotics are effective in treating small burn wounds with infection.	Work in 2018/19 will include further recruitment of patients at QVH and other sites with results due for publication September 2018.
Sentinel node biopsy for head and neck QVH commenced head and neck sentinel node biopsy in September 2016, following the recommendation made in NICE clinical guideline NG36: cancer of the upper aerodigestive tract: assessment and management in people aged 16 and over. During 2017, we achieved 100% of validation cases and commenced conventional sentinel node biopsy for head and neck cases.	The service hopes to introduce intraoperative fluorescence with nanocolloid binding to enhance the identification of appropriate lymph nodes. QVH is a mentor unit for other national units and hopes to expand this process to support other units. The head and neck cancer lead is on the external faculty board and is a member of the UK sentinel node biopsy training programme.

Patient Safety

2017/18 achievements	Further work for 2018/19
Clinical trials of a smart bandage which detects infections In clinical practice it is often difficult to truly diagnose infection before clinical symptoms are clearly observed. This gives bacteria the chance to multiply and cause tissue damage. Early identification using smart technology could lead to earlier diagnosis. The Trust is taking part in a large scale multicentre trial of a smart dressing developed by the University of Bath. Swabs and used dressings from hundreds of patients are being tested in the laboratory to see how sensitive the bandages are to the infections they are designed to detect. The colour-changing bandage will provide an early-warning that infection is developing, allowing swift treatment for patients. It will also prevent unnecessary tests in patients who do not have infection and avoid unnecessary use of antibiotics.	The use of the smart bandage may identify infection earlier and help to reduce complications. QVH will continue to recruit patients to this clinical trial during 2018/19 to ensure an adequate data sample for analysis, to prove whether the smart bandage has the intended benefits. Results should be made public in late 2018 and, if successful, the dressing may be manufactured in 2019 for the first patient trials.
Development of the world's first cranial nerve centre At QVH we are developing the world's first dedicated cranial nerve centre, treating all cranial nerve injuries and their complications including those with numb corneas, who are therefore at risk of blindness and those with paralysed tongues leading to speech and swallowing difficulties. This service is currently in its infancy but could revolutionise patient care in head and neck surgery worldwide.	In 2018/19 QVH will seek to expand this service to include those suffering from intractable facial pain. Pending discussions with commissioners and NHS England, future plans include treating those with voice-related disorders, for example after laryngeal/thyroid surgery, those with eyelid ptosis or lack of a blink response.
Sentinel node biopsy for melanoma QVH is the only centre in the south east of England to offer sentinel node biopsy for melanomas with a Breslow thickness greater than 1mm, as recommended by NICE guidance. The operation helps to find out whether the cancer has spread to the lymph nodes and is more effective than ultrasound scans at identifying small cancers.	This procedure requires collaboration with a nuclear medicine department and the service has already established links with two units in Kent. During 2018/19 the service aims to forge further working relationships with other nuclear medicine departments which will enable patients from other counties to access the service.
Immediate treatment for professional drivers The sleep disorder centre operates a consultant based service for all new patients. All patients are treated with reference to the NICE guidance on sleep disordered breathing, and advice is given on safety to drive and the DVLA regulations. QVH consultants have passed the European Sleep Research Society Certificate in Sleep Medicine within the last two years, and are experienced sleep physicians.	The service has responded to new guidance from the Sleep Apnoea Alliance to provide treatment for professional drivers with sleep disordered breathing within four weeks of referral. This will be challenging to maintain but we are working on processes to achieve this.

Patient safety achievements

2017/18 achievements	Further work for 2018/19
Scar study Scaring affects millions of people each year. Severely scarred areas require regular surgery to relieve tension across joints as the body grows and changes. To date there is no reliable effective treatment or cure. The scar study hopes to lead to new understanding and innovations in treatment. Researchers carefully process and store scar samples in order to provide a resource to analyse how the scar has formed. The scar tissue is donated by QVH patients undergoing surgical revision and the QVH scar collection is one of the largest in the world. Working with this valuable resource brings us a step closer to the ultimate goal of scar-free healing. By being able to work with human scar tissue we will better understand the process of scar formation. Scientists are looking at the role of key molecules and proteins in individual patients and that will help us to understand the body's own regenerative processes and eventually target the right treatment for patients.	Work in 2018/19 will include further developing our academic links. There are no scar tissue biobanks in the UK, and we hope this work in QVH will allow us to work towards the country's first, and help other research groups working on scarring, both nationally and internationally.

"At QVH we are developing the world's first dedicated cranial nerve centre, treating all cranial nerve injuries and their complications."

Effective

2017/18 achievements	Further work for 2018/19
Expanded glaucoma service The glaucoma service has invested in three new glaucoma laser treatments this year and offers a full range of minimally invasive glaucoma surgeries. This means that we are able to treat many more patients with glaucoma, with safer and less invasive treatment options than before. This innovative work has attracted media interest including a BBC broadcast. The director of the glaucoma service published and presented four international peer review papers in 2017 describing advances and innovations in minimally invasive glaucoma surgery.	The service will continue to expand to accept all new referrals for glaucoma from the surrounding regions. The glaucoma service is actively involved in clinical studies to further improve patient care, relating mainly to new surgical innovations in glaucoma treatment.
Nexobrid Following clinical trials of Nexobrid, an enzyme from pineapples that can breakdown burn tissue we are now using Nexobrid as a routine part of care. Surgeons and nurses at QVH are regarded as key opinion leaders in using Nexobrid and have spoken at several educational events and provide expert opinions for other burn clinicians who are beginning to use Nexobrid as part of their care.	In 2018 we will continue to provide support to other clinicians in using this treatment. Several publications are in the process of being written
Diagnosing sleep disorders The QVH sleep disorder centre routinely diagnoses all aspects of sleep disordered breathing using outpatient screening with oximetry or 'apnoea link', and other sleep disorders using inpatient sleep studies (polysomnography), in which brain waves and facial muscle tone are monitored for sleep staging overnight, enabling diagnosing of complex conditions such as epilepsy, non-rapid eye movement (REM) and REM parasomnias and limb movement disorders.	Education and research are integral and the department has presented four original projects at the biennial international meeting of the British Sleep Society in 2017, one reaching the top five in the judging panel. Posters were also accepted for presentation at the Acute Medicine Conference in London. In 2018/19 the centre will be undertaking further research for a group of patients with subcortical arousal in sleep who benefit from brain stimulant drugs. Once treated our patients are monitored on a shared care basis with GPs, and for most their quality of life has vastly improved.
Corneal neurotisation QVH is now established as the leading centre in the UK for this revolutionary sight-saving procedure which restores sensation to the cornea by using nerve grafts. We have the largest worldwide series of corneal neurotisation procedures in adults and in total, second only to that of the Toronto Hospital for Sick Children. QVH is the main centre for reinnervating the cornea in the UK and Europe.	The team collaborates with Moorfields Eye Hospital to monitor corneal sensory patterns using confocal microscopy. This work was presented at national and international meetings in 2017 and received the Foulds Trophy at the Royal College of Ophthalmologists' annual congress and also the award for best presentation at the European Society of Ophthalmic Plastic Surgeons annual congress at the Karolinska Institute, Stockholm. QVH is planning to expand this service to treat children during 2018/19.
Stem cell therapy in cornea stem cell deficiency QVH is the only cornea centre in the UK which performs mouth to eye epithelial transplantation as a method of stem cell therapy in cornea stem cell deficiency. The procedure has been performed for the last five years with a success rate of over 65% which is an excellent outcome. Descemet's membrane endothelial keratoplasty is the third and most advanced generation of customised tissue specific corneal grafting. QVH is one of the very few centres which pioneered this procedure and our consultant also teaches this new procedure to colleagues both nationally and internationally.	The paediatric cornea service at QVH continues to expand and the Trust is becoming a large national referral centre for paediatric Stevens Johnson syndrome. Complex paediatric corneal cases are referred to our unit from all parts of the UK and some European countries.

Clinical effectiveness achievements

2017/18 achievements	Further work for 2018/19
QVH comprehensive facial paralysis screening protocol Building on the Harvard screening model for facial paralysis, QVH has now added further innovations and improvements to its screening tests, making it the safest and most comprehensive screening tool in the world of facial paralysis care. This is essential as up to 30% of all cases of facial paralysis, are not due to Bell's palsy. Other causes include undetected cancers and minor strokes. Our system is the most likely to provide answers for patients and give them real solutions.	The team are building closer ties and networks with neurosurgery, neurology, neurophysiological, virology centres in the south of England, and building on the improved detection rates with our innovative screening tools.
Super-selective neurotisation World-first: Clinicians at QVH have recently developed a novel surgical procedure using the branches of the masseteric nerve to target specific smile muscles and transfer neural energy in a synergistic manner. This is a less invasive and shorter procedure, specifically designed for the augmentation of the weak smile and is showing promise over contemporary procedures such as the Labbé procedure and free functional muscle transfers.	At the 2017 International Symposium for the Facial Nerve in Los Angeles, QVH clinicians showcased to the wider medical fraternity, the benefits of super-selective neurotisation for the management of the weak smile; eliciting interest from surgeons from across the globe in coming to QVH to learn this revolutionary technique. This further adds to the position of QVH as a world-class institution. In 2018/19, selective neurotisation will be extended to those suffering from severe facial spasms (synkinesis). Combining this with selective neurolysis, QVH clinicians are developing major inroads into the 'combo' concept in synkinesis management; a life-changing procedure, for those afflicted with chronic facial paralysis.
Supermicrosurgical free tissue transfers Using a technique developed in Japan, QVH now offers multi-component (chimeric) nerve free flaps including skin, fat and/or muscle for the early reanimation of facial paralysis. This is ideal in reanimating the face as well as re-establishing the normal contour and surface anatomy of the face. Vascularised nerve grafts have been recognised as having the highest success rate of nerve regeneration world-wide and are ideal for very complex facial nerve injuries and in those with extensive scarring from surgery or radiation.	Building on the superficial circumflex iliac artery perforator chimeric flap model, QVH clinicians are now able to offer those with facial contour deformities, the gold standard in facial contouring, free vascularised fat transfers. The results are excellent long-term as a single surgery often suffices.
Selective neurolysis/'combo' procedure Europe-first: Using a novel technique recently developed in the USA, QVH offers selective neurolysis; the most advanced surgery available worldwide for synkinesis. This technique provides a permanent solution for patients with severe synkinesis, recalcitrant to botulinum toxin treatment. Our patient related outcome measures have been excellent.	World-first: QVH has now further developed the selective neurolysis technique and fused it with nerve-muscle neurotisation to provide a synergistic effect for smile reanimation. QVH believes that this approach will radically change the treatment of facial palsy.
Enhanced recovery for free-flap breast reconstruction The QVH enhanced recovery programme for breast surgical patients aims to reduce the physical trauma of surgery. It is a collection of strategies in a structured pathway that supports the multidisciplinary team (surgical, anaesthesia, allied health professionals and ward staff) to work together to optimise patient outcomes, including early discharge where appropriate. With continued adherence to the free-flap breast reconstructive ERAS (enhanced recovery after surgery), a mean operative stay of 3.9 days has been maintained over the last year. An audit is in progress to ensure the effectiveness of the pathway and to review its impact on patient care.	Following the success of the ERAS pathway for free-flap breast reconstruction, we are in the process of developing an ERAS pathway for breast reduction surgery.

Clinical Effectiveness

2017/18 achievements	Further work for 2018/19
Immediate/early facial nerve repair The close working relationship between plastic, maxillo-facial, corneo-plastic and ENT surgery teams now allows QVH to offer immediate/early repair of all damaged facial nerve branches from the forehead to the chin, following previous surgeries and trauma. This has successfully allowed the best results to be achieved in the shortest possible time (within six months), irrespective of the patient's age.	QVH is now setting immediate/early nerve repair of facial nerve injuries as the standard of care for all patients within the South East of England trauma network and for post-op facial nerve complications within the region. This sets a new UK and global gold standard of care in the management of facial paralysis. Future plans include providing a tertiary referral centre for those with facial paralysis following aesthetic procedures.
Clinical electroporation This NICE approved treatment combines a low dose chemotherapy drug and an electrical pulse applied directly to the cancer cells. This allows more of the cancer drug to enter the cells with a dramatic increase in the effectiveness of treatment. This treatment can enhance the quality of life of palliative patients with recurrent or persistent cancer nodules. Electrochemotherapy treatment has been available at QVH since summer 2017 for head and neck, skin and breast cancer patients. The service is subject to continual audit to ensure high and sustained quality outcomes and that it meets the needs of our patients.	It is expected that QVH will see an increased number of referrals in 2018/19 for skin and head and neck patients, extending the availability of this treatment.

"Electrochemotherapy treatment has been available at QVH since summer 2017 for head and neck, skin and breast cancer patients."

Caring

2017/18 achievements	Further work for 2018/19
QVH acute facial paralysis clinic QVH has one of the most sophisticated facial therapy and rehabilitation services in the world with a full team of dedicated facial therapists. We provide an acute clinic for all patients recently affected by Bell's palsy or the malevolent effects of facial paralysis, where early care can be provided by therapists' one-to-one, over the phone or online.	QVH is developing links with its surrounding emergency departments to improve the management of patients with Bell's palsy after their initial diagnosis. This allows for the initiation of treatment earlier. We are in the process of incorporating virtual reality programmes and smartphone app-based technology into the rehabilitation of facial paralysis patients, a global-first. This will include those with facial paralysis due to strokes.
Streaming sleep physiological data from patient homes Over 15,000 patients are now treated with a positive airway pressure ventilator and bi-level non-invasive ventilator. New developments include using technology which streams physiological data to the department daily from the patient's home so that specialist staff can check the compliance and effectiveness of treatment.	Increasing use of technology will move outpatient appointments into virtual clinics. This will decrease the number of times the patient will need to travel to attend an outpatient's clinic appointment and enable equipment setting changes to be performed to the machine over the internet.
Scarless and/or minimal access surgery Facial paralysis surgery often leaves stigmatising scars for those undergoing treatment. QVH is at the forefront of addressing this, both in terms of psychology and surgery. We aim for all surgical scars to be hidden within the hairline, facial creases or within the lip. The vermilion mucosal advancement flap is an example of our commitment to this ideal as is the modified Labbé procedure for smile reanimation. This allows patients treated at QVH to have minimal scars compared to the current norm in facial palsy surgery.	From 2018 onwards, QVH will be performing endoscopic techniques in facial palsy surgery e.g. when harvesting nerve grafts and for corneal neurotisation procedures. This allows for reduced patient morbidity post-op and even more discrete scars.
Nurse led provision of local anaesthetic for nipple tattooing Following patient feedback, and to improve patient experience, our breast care nurses have undergone training enabling them to give local anaesthetic to patients at the time of nipple tattooing. QVH continually considers the holistic assessment and treatment of all patients. This is particularly the case for our breast patients who have had life changing treatment.	QVH will continue the nipple tattoo audit to help identify improvements to the service and care and experience of our patients.

Responsive

2017/18 achievements	Further work for 2018/19
Trauma clinic opening The new trauma clinic opened in September 2017. The service resolves the privacy and dignity issues for patients waiting to be seen in both the Minor Injuries Unit (MIU) and the trauma clinic which previously ran alongside each other. This move has provided a dedicated area with co-located medical staff and trauma co-ordinators which offers a seamless flow for patients. This has increased capacity and enhanced the patient experience. The unit also includes a fully supported procedure room to facilitate treatment on the day and reduce the number of cases going to main theatres. Joint hand and maxillofacial weekend clinics are also being held.	Work will be taken forward to extend the complexity of procedures undertaken in the clinic to ensure that more patients receive treatment on the same day, rather than needing to return. An increased range of procedures will also help to alleviate pressures in main theatres. Performance metrics will be formulated to measure and monitor the effectiveness and efficiency of the new service.
Burn time from referral to specialist review Burn wounds require specialist review to prescribe the most effective treatment for healing and to reduce the risk of infections and scarring. We aim to see patients with small burns that are unlikely to need admission to the burn service and can be managed with outpatient dressing within 48 hours of referral. We are auditing our ability to comply with this standard and investigate if we can improve our efficiency.	In 2018 we will continue to record time from referral to assessment and investigate methods of improving this such as additional appointments.
Burns time to surgery once needed Our aim is that when a burn is assessed as requiring surgical intervention, a patient should be offered the next available theatre slot. The burn service runs three theatre lists per week and has six beds, four in a single bay, which limit the number of male or female patients able to be housed in the burns service at any one time. The service audits theatre delays to understand the reasons, and then reviews the results at the burns governance meeting.	In 2018 we will continue to audit time to surgery and look at ways of reducing patient waiting times.
Head and neck cancer surgery - patient satisfaction In addition to the national cancer patient satisfaction survey we have undertaken a West Kent multidisciplinary team patient satisfaction survey in 2017. This showed high levels of satisfaction, and some areas for improvement. This survey encompassed the entire head and neck patient pathway including patient flows between the four trusts within the network.	In order to better reflect the patient experience through QVH specifically, we are developing a patient questionnaire targeted only at the surgical component of the pathway. We will use this feedback to further improve services, for example, the effect of free flap monitoring, pain, nausea and vomiting control.

2017/18 achievements	Further work for 2018/19
QVH community services Community services in QVH have grown over the last 12 months, with expansion of the community ENT service to a new site at Tangmere, West Sussex and the clinics in Crawley and Worthing, West Sussex offering appointments each week. GPs can refer patients to a consultant-led outpatient service that provides rapid and comprehensive assessment, diagnosis and treatment for non-urgent conditions. The service includes a range of on-site diagnostics with day case surgical interventions where appropriate, and support for GPs with advice if needed. The community urology service has been steadily growing over the last 12 months and we are now able to offer patients a choice of days to see a consultant. There are a number of local procedures that can be undertaken quickly and efficiently to ensure that the patient is seen and treated as soon as possible	In 2018/19 QVH is looking to expand some of our community services to other locations to help ensure patients are seen and treated in a local setting. This will investment in equipment to ensure these services are able to provide the range of diagnostics so patients are seen and treated as soon as possible.

Well led

2017/18 achievements	Further work for 2018/19
Freedom to Speak Up Guardian Following recommendations of the review by Sir Robert Francis into whistleblowing in the NHS, QVH has appointed a Freedom to Speak Up Guardian. The Freedom to Speak Up review made recommendations on the need for culture change and improved handling of staff concerns nationally. The Trust appointed a Freedom to Speak Up Guardian in April 2017 via staff election. The role of the guardian is to engage staff to raise concerns regarding patient safety and patient satisfaction. The guardian reports directly to the Trust board. The post has been well received with staff feeling confident to approach the guardian and raise concerns. The guardian actively engages with local and national networks to share best practice and support.	The guardian will continue to present to the Trust Board four times a year and meets with the chief executive on a monthly basis. Additional hours have been allocated to the role to enable the guardian to work one full day a week and undertake a proactive approach in promoting the role and engaging with staff across the Trust. Data on the number of concerns raised continues to be submitted to the national guardian's office.
Oculoplastic surgery and the QVH facial palsy service The oculoplastic team collaborates closely with the QVH facial palsy service as a multidisciplinary team. The oculoplastic team published five research publications on facial palsy in 2017. One of the corneoplastic unit consultants was invited as keynote speaker at the International Facial Nerve Symposium, the largest interdisciplinary symposium for facial nerve specialists. The oculoplastic team published 14 research papers in 2017, including a major review on the management of ichthyosis and also the use of hyaluronic fillers in oculoplastics.	The Trust's oculoplastic team and prosthetics department have commenced a national portfolio study on artificial eyes.
Raising national awareness of facial paralysis In March 2018, members of the facial paralysis team presented to MPs at the House of Commons to increase awareness of the plight of those suffering from Ramsay-Hunt syndrome and other causes of facial paralysis. This will hopefully address the lack of funding of the treatment of those with facial paralysis.	Future plans include seeking to ensure treatment of facial paralysis is available to patients in Wales and Northern Ireland, where there is currently no such service.
Perforator, microvascular and preplanning Course 2018 In January 2018, the head and neck cancer team developed and ran a perforator, microvascular and preplanning course which was supported by colleagues from plastic surgery. This was a cadaveric course held in conjunction with the University of Brighton. The delegates included senior surgical trainees, fellows and consultants. The course was highly evaluated by delegates.	Due to the success and popularity of the course, the head and neck team plan to run this course annually and expand the delegates able to attend.

Statements of assurance from the Board of Directors

Review of services

During 2017/18, Queen Victoria Hospital NHS Foundation Trust provided 21 NHS services including burns care, general plastic surgery, head and neck surgery, maxillofacial surgery, corneoplastic surgery and community and rehabilitation services. QVH has reviewed all the available data on the quality of care in all of its NHS services. The income generated by the relevant health services reviewed in 2017/18 represents 90% of total of the total income generated from the provision of relevant health services by QVH for 2017/18.

Research

Pioneering techniques developed at QVH in the past are now used routinely in the care of patients all over the world. This includes burns reconstructive surgery, cell culture and hypotensive anaesthesia. Our current research programme focusses on developing techniques in wound healing and reconstruction. We are proud to be holders of grants from the National Institute for Health Research for both research for patient benefits and invention for innovation, as well as Medical Research Council grants, and believe this reflects the quality of our research.

We have established new collaborative work with the University of Oxford and the University of Nottingham Trent. Wide networks are critical to successful research investment and outputs, particularly in the specialised fields of practice we undertake here at QVH. We are grateful for the ongoing support of our local clinical research network for core research infrastructure, and have significantly increased our participation in national portfolio studies.

The total number of participants recruited to research ethics committee approved studies in 2017/18 was 539, with QVH taking part in 32 studies; of these 539 participants, 442 were National Portfolio recruits.

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

Participation in clinical audits and clinical outcome review programmes

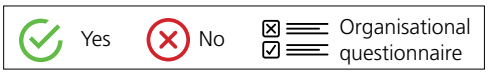
A clinical audit is a quality improvement cycle that involves measuring the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes.

During 2017/18, seven national clinical audits and five clinical outcome review programmes (previously known as confidential enquiries) covered health services that QVH provides.

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

Participation in national clinical audits 2017/18

National Clinical Audit and Clinical Outcome Review Programmes



6th National Audit Project of the Royal College of Anaesthetists - Perioperative Anaphylaxis, UK

Applicable | Participation comments | % of cases submitted

Breast and Cosmetic Implant Registry - a continuous data collection model.

Applicable | Participation comments | % of cases submitted

Falls and Fragility Fractures Audit programme National Inpatient Falls

Applicable | Participation comments | % of cases submitted

Mandatory Surveillance of bloodstream infections and clostridium difficile infection

Applicable | Participation comments | % of cases submitted

National Ophthalmology Audit - a continuous data collection model.

Applicable | Participation comments | % of cases submitted

Perioperative Quality Improvement Programme

Applicable | Participation comments | % of cases submitted

Seven Day Hospital Services Self-Assessment Survey

Applicable | Participation comments | % of cases submitted

Participation in clinical outcome review programmes 2017/18

National Clinical Audit and Clinical Outcome Review Programmes

Learning Disability Mortality Review Programme

Applicable | Participation comments | % of cases submitted

Child Health Clinical Outcome Review Programme Children with chronic neurodisability

Applicable | Participation comments | organisational questionnaire only

Child Health Clinical Outcome Review Programme (NCEPOD*) Young People's Mental Health

Applicable | Participation comments | % of cases submitted

Medical and Surgical Clinical Outcome Review Programme - perioperative diabetes

Applicable | Participation comments | % of cases submitted

National Mortality Case Record Review Programme (previously Retrospective Case Record Review, funded by NHSI)

Applicable | Participation comments | % of cases submitted

* National Confidential Enquiry into Patient Outcome and Death

National clinical audit

Three national clinical audits were reviewed by QVH in 2017/18.

Medical and surgical clinical outcome review programme (NCEPOD): inspiring change - non-invasive ventilation

This NCEPOD report focuses on the quality of acute non-invasive ventilation in clinical care, for patients aged 16 years or older who are admitted to hospital. The report takes a critical look at areas where the care of patients might have been improved. Remediable factors have also been identified in the clinical and the organisational care of these patients. Whilst QVH did not take part in this national audit, the report has been clinically reviewed by our anaesthetic governance lead with a view to implementing changes within the department.

National audit of inpatient falls

The falls and fragility fracture audit programme is a national clinical audit run by the Royal College of Physicians, designed to audit the care that patients with fragility fractures and inpatient falls receive in hospital. QVH was found to have areas of excellence compared to the national picture, which included recording and assessing patient mobility, ensuring that patients have safe footwear, and reducing risk by ensuring that the area around the patient is hazard free and that a call bell is easily visible and within reach. We were also better at assessing patients' vision than the national average, but there is still room for improvement, especially in documenting patients' vision care requirements. Whilst undertaking the audit, immediate improvements were introduced including standing blood pressure and a maple leaf sign highlighting those patients at risk of falling. Work is underway to improve the documentation of delirium and incontinence/toilet requirements and patients with 'fear of falling assessment' (given to all patients who have had previous falls). This work is planned to be completed by the end of June 2018.

Diabetes inpatient audit

The National Diabetes Inpatient Audit is an annual snapshot audit of diabetes inpatient care in England and Wales and is open to participation from hospitals with medical and surgical units. QVH was unable to participate in this national audit due to our specialist nature. However, due to the increasing prevalence of diabetic patients across the country, it was felt important for QVH to undertake its own internal audit using the national tools to evaluate the care provided to patients. Results identified areas of improvement and specific diabetes training has now been added to induction training for nursing staff.

Local clinical audits

The reports of 65 completed local clinical audits and were reviewed by QVH in 2017/18. Examples of audit projects undertaken across QVH, their finding and actions taken as a result are set out below.

End of life care audit: dying in hospital

QVH recognises the responsibility of hospitals to deliver high-quality care for patients in their final days of life and appropriate support for their families, carers and those close to them. QVH was not included in the national audit because of its specialist nature; but we measured ourselves against appropriate national standards to ensure that we continue to meet and improve the quality of care and services for patients who have reached the end of their life. This clinical element was based on a set of case note review questions which were devised to reflect the five priorities of care for the dying patient and involved consultation with a multidisciplinary audit steering group. Results were in line with national guidance and identified that changes need to be made to the end of life care plan to make it more user-friendly to encourage usage. A staff confidence survey will also be undertaken to help identify training needs when looking after patients and completing their care plan.

A five-year retrospective analysis of the characteristics of patients with self-inflicted burns injuries

Self-inflicted burns (SIBs) are a significant cause of burns morbidity worldwide. A sub-group of SIB patients demonstrate recurrent SIB behaviour causing repeated morbidity and an increasing strain on hospital resources. The ability to predict which patients are likely to demonstrate repeat behaviour will allow for more targeted interventions in this group. This study aimed to identify the factors that differentiate patients who repeat SIB from those who commit SIB as an individual occurrence. A total of 75 patients were included in the study, and data was collected using the International Burns Injury Database and a follow up retrospective review of patient notes.

Recurrent SIB patients appear to have their own defining characteristics when compared to individual occurrence SIB patients. These patients are more likely to be caucasian and female, with the mean total body surface area burn for repeat SIB being 60% less than for individual occurrence patients. Smoking and BMI do not appear to differentiate between repeat and individual occurrence patients. The majority of patients appear to have sustained their injuries outside normal working hours. The potential to reliably predict which patients are likely to repeat SIB is now a very real possibility. This will allow for more targeted interventions, and there is potential to save patients from significant morbidity and hospitals from significant resource strain. The next step is to utilise national or multi-centre data to build a more robust prediction tool and begin to clearly define the effective methods of SIB recurrence prevention.

Front of neck access: emergency strategies and equipment

Changes to national guidance recommends surgical airway as the best option for front of neck access (FONA) in an emergency where a tube cannot be inserted into a patient for them to receive the necessary oxygen. A questionnaire was completed by all anaesthetists (consultants and trainees) to review training received in FONA, equipment they would want and what choice of emergency airway they would use in this scenario. In addition, the time taken for theatre staff to bring all equipment needed and a review of the difficult airway trolleys used at QVH was also undertaken. Results found that there was excess non-essential equipment on the difficult airway trolley in theatres which differed from those used elsewhere. There was a spilt in the anaesthetists of the choice of FONA and it was found that theatre staff took 15-125 seconds to find equipment needed for emergency surgical airway. In response to these findings, difficult airway trollies have been standardised and grab bags are now available in each theatre or anaesthetic room with all equipment needed for an emergency surgical airway.

Nerve damage following surgery to lower third molar related to new radiological sign juxta apical radiolucency (JAR)

Nerve damage following surgery of lower third molar is a rare but potentially life changing complication and all efforts are made to reduce its occurrence. This audit looked at the extent to which the preoperative assessment and treatment of patients with a specific radiological sign (JAR) complies with national and local recommendations and policies.

A total of 734 radiographic examinations of patients who have undergone surgery of their lower third molars have been reviewed in order to identify patients with the new radiographic sign. Of these patients, 51 sets of patient notes (presenting with juxta apical radiolucency) were analysed and patients were contacted by telephone to review the outcome of the operation in relation to nerve damage. 49 patients confirmed that they did not experience permanent postoperative nerve injury.

The juxta apical radiolucency (JAR) was identified and reported in only 7 cases (13%). According to written records, removing the crown of the tooth and leaving the roots intact which allows them to heal over with bone (coronectomy) and x-rays (cone beam computed tomography (CBCT)) were discussed and offered in 16 (31%) and 13 (25%) cases respectively. NICE guidelines and consent forms were correctly used in over 96% of the cases. The use of a leaflet was recorded in the notes in only one case.

There was a general agreement that increased awareness was needed on appropriately recognising and reporting JARs on plain radiography. A specific leaflet for coronectomy is currently under production and will be appropriately used in conjunction with the generic leaflet for wisdom teeth removal. Results found that record keeping was generally of a high standard, but additional effort is needed to report on whether or not CBCT and/or coronectomy were discussed, and recording patient's wishes and documenting the use of leaflet.

Is the lower limb group effective for rehabilitation of patients with lower limb pathologies and does it provide good patient care

The lower limb class is run weekly for patients recovering from any lower limb injury or surgery, and patients are booked to attend for six consecutive weeks. This year's audit was carried out between July 2016 and 2017 and uses the Measure Yourself Medical Outcome Profile (MYMOP) and Lower Extremity Functional Scale (LEFS) outcome measures to assess patient progress within the class, with a patient satisfaction survey also being completed at the end of the six weeks.

Results show a significant clinical change in both outcome measures with trauma and post-operative patients experiencing most benefit. Consistently 90% or more patients reported enjoying the class, feeling stronger and more confident having achieved the goals that had been set with clear explanation and support elicited by therapists.

Balance and bone group patient satisfaction and clinical outcomes 2017

The balance and bone group is run by a physiotherapist and occupational therapist once a week for eight weeks for those at risk of falls and incorporates exercise and educational talks. It aims to reduce the risk of falls and therefore prevent the likelihood of associated injury and hospital admission. This audit allowed us to gain valuable feedback from patients and act upon this to ensure methods of delivery are optimised. Feedback received through questionnaires and was overwhelmingly positive. 100% of responses suggested that the class was enjoyable, therapists were supportive and explained everything clearly, the class resulted in patients exercising at home, and increased confidence and strength. Only one patient reported that they did not feel a benefit of the 'what to do if you fall' and 'caring for your feet' talks.

The Tinetti outcome is used to assess effectiveness of the class and is designed to assess gait and balance in older adults. It is a performance-orientated mobility assessment. Besides giving information on manoeuvrability, it is also a very good indicator of the fall risk of the tested person. Scoring ranges indicate whether the individual is at low (≥24), moderate (19 – 23) or high (≤18) risk of falls. Patients moved from a pre-class moderate risk of falls to a post class low risk of falls on average. Along with this, measures of a 180° turn improved with fewer steps being taken on average. These results indicate that the class is an effective tool at reducing the risk of falls in this patient group.

National clinical audit

Three national clinical audits were reviewed by QVH in 2017/18.

Nailbed audit

There were no QVH guidelines on the optimum treatment for children with nailbed injuries and treatment is dependent on the surgeon's own preferences. This audit aimed to establish the treatment process for children with nailbed injuries and use evidence based practice to determine the best treatment plan to facilitate healing. A sample of 90 children was anonymously selected from the ward trauma diary from a three month period between July and October 2017. Findings suggested that the majority of children with nailbed injuries had surgical interventions rather than being treated conservatively. The nailbed was generally left off, with few occasions of it being put back on, however the rationale for this was rarely stated. Dressings had many variables, generally a non-adhesive layer, padding and a finger bandage, with various padding added dependant on the age of the child and surgeon preference.

Most children had a standard two week follow up appointment in the paediatric assessment unit when the wound was fully healed with no sign of infection. Occasionally children were invited for review after just one week and the finger would be healed, without infection. Some cases had follow up care with their GP surgery, however it is not known if these children were healed or had any infection. There is no current standard for treatment of nailbed injuries, however a national research study commencing in 2018 will endeavour to set a nationally agreed standard for the care of these injuries and once these standards are ratified, this audit will be repeated against those set standards.

Burns donor site dressing literature review audit

The burns service has been auditing in QVH the current trend in dressings for the donor site of patients who have undergone a split-thickness skin graft. Split-thickness skin grafting is a widely used reconstructive technique for the replacement of damaged or missing skin secondary to burns, trauma, surgical resection for cancer, and chronic wounds. Split-thickness autografts are harvested by excising the epidermis and part of the dermis, leaving a donor site wound that can vary in thickness. Donor site wounds generally heal by migrating cells into wounds (reepithelialisation) in 7-14 days. There is a plethora of dressings available for the treatment and management of donor sites, however it remains unclear which type of dressing is superior. The goal of this audit was to determine, after going through the international literature, which donor site dressings are associated with the best outcomes for pain, infection rate, healing time, quality of life, and cost. Early results show that our current treatment regimes reflect best practice in accordance with findings published in international literature.

Length of inpatient stay following orthognathic surgery

Length of stay is a performance indicator for surgeons. It has vital cost implications and is a key factor in enhancing a patient's journey. Research has found that patients considered a length of one night's stay as acceptable. The aim of this audit was to determine the length of post-operative stay following orthognathic surgery and identify the re-admission rate. The audit sample included all patients who underwent orthognathic surgery from October 2015 to September 2016 and standards were set following a published multicentre study looking at the type of surgery performed. Results were in line with published evidence and found that local infrastructure would prevent safely discharging patients on the same day. Factors include operation on the afternoon list, late return from theatre, the need for two post-operative doses of antibiotics and steroids, and discharge paperwork.

Cataract surgery – are we meeting patients' vision?

At QVH, we carry out an annual audit on vision outcomes following cataract surgery as defined by the Royal College of Ophthalmologists (RCO) Guidelines on Cataract Surgery 2010, benchmarking those achieving equal or better than 6/12 vision. This level is a good indicator if the patient meets the legal driving standard. We compared patient reported outcome on the ease of ability to drive during the day/night and ability to read small print/newsprint/large print unaided following cataract surgery at their routine 4-6 week post-operative check when their glasses were not updated, against unaided vision achieved following cataract surgery. We also looked at patient reported improvement in their quality of life following surgery and their overall experience at QVH.

Patients seen in the QVH optometrist cataract follow-up clinic in April and May 2017 who did not have any intra or post-operative complications or any pre-existing ocular pathology were included in the audit.

Our cataract post-operative results are excellent with 100% achieving corrected vision of 6/12 in comparison to RCO guidelines of 92%. In fact 88% achieved 6/12 or better unaided. Driving and watching TV are good measures of distance vision and most of our patients were able to drive without glasses after surgery. This is reflected well in patients' quality of life activity scoring where the average score was 4.9 (out of maximum score of 5) implying that they had no difficulty driving in daytime following surgery. More people watched TV than drove, again achieving an excellent average score of 4.8. Our standard practice for target refraction is emmetropia or slightly on the myopic side. It is expected that patients will have some difficulty reading unaided, which is reflected in the average score of 3.6.

Women's health

The purpose of this audit was to see how effective the women's health service is and whether any changes need to be implemented to improve the service. The audit monitored the number of referrals into the service and explored which conditions were being treated. A satisfaction survey also showed whether patients were happy with the treatment they received.

Results of this year's audit were very positive with all patients feeling that they had made positive changes to their condition even if they had not met all of their objectives. The 'measure yourself medical outcome profile' indicated that the women's health service has a clinically significant effect on the vast majority of those referred. The quality of life score showed great improvements; 91% of patients initially scored high on the quality of life score showing them to be unhappy or dissatisfied with their condition. All of these improved when reviewed at discharge, with 85% of patients being happy with the outcome of treatment and only 15% of patients stating that they were equally satisfied or dissatisfied.

The patient satisfaction survey gave patients the opportunity to comment on their treatment experience and make suggestions to improve the service. All comments were positive and showed how patients felt the service had benefitted them.

Identification and remediation of oro-motor functions in patients presenting with lower motor neurone facial palsy

The aims of this audit were to identify and describe the type of problems patients were experiencing with eating, drinking and other oro-motor functions as well as identifying whether the number and frequency of these problems could be significantly reduced over the course of a standard treatment programme. All participants experienced a range of oro-motor dysfunction pre-treatment. Major concerns reported by patients related to functions associated with lip rounding, lip sealing and impaired buccinator function as well as feeling less able or willing to participate in activities of daily living. All patients improved using the standard treatment programme in all aspects of oro-motor function including speech, and these improvements promoted social engagement. However, whilst improvements were highly significant some patients continued to experience problems once active treatment was complete. It may be that therapy needs to focus on a more graded approach to strengthening exercises in order to address these issues.

Using biopatch dressings in major burns patients to reduce catheter related blood stream infection

Burns patients are particularly at risk of catheter related blood stream infection (CRBSI) due to disruption of the normal immune response and breach of the skin barrier. This audit was undertaken to see if CRBSI could be reduced in this patient group by using biopatch dressings on central venous catheters. Biopatch dressings were applied to the central venous catheters of all burns patients admitted to the unit between April and September 2016. At the end of this period, the incidence of CRBSI in this sample was compared to the incidence in the sample during the six months prior to its introduction. Results found a possible reduction of CRBSI of 52% in burns patients with central venous catheters where the biopatch dressing was used.

Musculoskeletal physiotherapy – patient satisfaction

From the 2016 result of the musculoskeletal physiotherapy patient satisfaction the main aims were to provide online video instruction for ease of exercise completion as well as continuing to reduce waiting times. We have now begun to use video demonstrations for some of our shoulder exercise prescription. Waiting time management has been challenging and has mirrored the fluctuation in staffing levels.

Although waiting times are still a challenge, results of the 2017 satisfaction survey showed that 98% of patients rate the service as 'good' or 'excellent', 96% were happy with communication methods and delivery with 100% responding positively regarding communication from therapists. 98% of patients felt they were able to ask questions with 1% feeling they could not. 98% felt listened to and included in the decision-making around their care with the remaining responses left blank.

Overall it has been another positive year and feedback reflects that. Patients are generally very happy with the care they receive. The biggest challenge we are facing at present is reducing waiting times. Actions have already been taken by increasing the musculoskeletal physiotherapy establishment which will have a significant benefit on our capacity and subsequently reduce waiting times.

Commissioning for Quality and Innovation payment framework

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

A proportion of QVH income in 2017/18 was conditional on achieving number of national and local CQUIN goals. We secured 99% of our CQUIN targets generating £892,138 of income.

For our local dental schemes, we achieved 100% our local targets generating £241,243 of income.

The national quality initiatives were:

1. **Introduction of health and wellbeing initiatives**
   QVH has taken numerous measures to improve staff health and wellbeing throughout 2017/18. As well as the musculoskeletal physiotherapy self-referral scheme, established in 2016 and free for all staff, QVH has introduced and promoted health and wellbeing schemes such as Care First/Zest, pilates and mindfulness for stress and wellbeing courses for staff. On a weekly basis, the QVH internal newsletter has a dedicated space for staff health and wellbeing promoting the free services and initiatives available to staff and healthy behaviour. Examples of these include counselling services, good hydration during the hot months and healthy sleeping habits.

2. **Healthy food for NHS staff, visitors and patients**
   Improving our patients' experience of QVH food was a major goal in 2016/17 and continued through 2017/18. As part of this national CQUIN, we have taken forward a number of initiatives to ensure that a choice of healthy food is available to patients and staff. Healthy options are available in all catering outlets including vending machines for staff working out of hours. During 2017/18 QVH has been regularly monitoring the proportion of drinks and food which comply with the CQUIN guidelines. We have seen significant reductions of drinks and food high in calories, salt, sugar and fat. There are no longer price promotions or advertising for foods high in fat, sugar and salt. The vending machine displays have been improved to encourage water bottle sales, putting less healthy contents on lower shelves and displaying sugar and calories contents.

3. **Improving the uptake of flu vaccinations for front line staff**
   Seasonal influenza (flu) is an unpredictable but recurring pressure that the NHS faces every winter. Vaccination of frontline healthcare workers against influenza reduces the transmission of infection to vulnerable patients who are at higher risk of a severe outcome and, in some cases, may have a suboptimal response to their own vaccinations.

   Vaccinating frontline healthcare workers also protects them and their families from infection.

   The national CQUIN measured from October to December each year stipulates that trusts are required to vaccinate 70% of frontline staff as part of an annual immunisation programme. For the 2017/18 programme, a CCG locally agreed variance to the CQUIN was introduced which allowed QVH to include all staff members who had the vaccination elsewhere or declined. QVH achieved the CQUIN in full, with 72.6% of staff engaged and a 58.9% vaccination rate.

4. **Timely identification and treatment of sepsis in acute inpatient settings**
   Sepsis is a common and potentially life-threatening condition that can lead to widespread inflammation, swelling and blood clotting. This can lead to a significant decrease in blood pressure, which may reduce blood supply to vital organs such as the brain, heart and kidneys. Sepsis is recognised as a significant cause of poor outcomes and death, and is almost unique among acute conditions in that it affects all age groups.

   QVH has very few patients each year with suspected sepsis, or those who go on to develop it. Where sepsis is suspected, patients are managed in accordance with the Sepsis Six pathway and treatment is provided.

   In 2017/18 the adult patients' pathway was reviewed and now includes treatment guidelines for sepsis and a prescription chart. The pathway must be completed for all patients treated with sepsis. The Trust is in the process of procuring a nursing e-observation system which will enable clinical staff to record patient vital signs quickly and easily, and will automatically alert appropriate clinical staff if a patient's scores are outside the normal range, as is the case when patients develop sepsis.

5. **Reduction in antibiotic consumption per 1,000 admissions**
   The misuse of antibiotics is a globally recognised problem. QVH has reviewed national guidance and taken a number of steps to reduce the unnecessary prescribing of antibiotics across the Trust. This will help to decrease the spread of antimicrobial drug resistance. We monitor and scrutinise our antibiotic usage on a monthly basis, and report our data externally to Public Health England quarterly. To support this QVH is delivering internal training to all clinical staff to ensure levels of antibiotic prescriptions are kept to a minimum and only used where absolutely necessary.

6. **Empiric review of antibiotic prescriptions**
   All hospitalised patients who are prescribed antibiotics at QVH are safeguarded by consistent assessment reviews. This ensures that antibiotics are being used appropriately and provides our patients with the best possible care and treatment. In 2017/18 QVH launched an antimicrobial app to promote adherence to guidelines.

Offering advice and guidance

QVH is committed to providing advice and guidance services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients into QVH specialist burns care, general plastic surgery, head and neck surgery, maxillofacial surgery, corneoplastic surgery and community services. QVH is using functionality within the e-referral system to support GPs.

NHS e-Referrals

NHS England has developed the e-RS CQUIN for 2017/18 with the aim of increasing the availability of services and appointments on provider e-RS systems and promoting a paperless environment. By end of quarter 3, QVH had achieved its target of 90% of referrals to first outpatient services being able to be booked via e-RS for burns care, general plastic surgery, head and neck surgery, maxillofacial surgery, corneoplastic surgery and community services.

Supporting proactive and safe discharge

QVH has committed to improving the discharge process for patients across all wards within the Trust. We are working throughout a two year period (2017-2019) to ensure an improvement in the patient outcome, improvement in patient flow and reduction in delayed discharges. In 2017 QVH successfully implemented a successful complex discharge care plan Trust-wide.

Dental

There were three dental CQUINs in 2017/18:

1. Orthodontics buddy arrangement – where QVH receives a number of less complex cases for agreed training purposes.

2. Referral management and triage - throughout 2017/18 QVH has worked on embedding the Dental Electronic Referral System (DERS) and we now only accept referrals from General Dental Practitioners electronically, including the receipt of x-rays.

3. Dental managed clinical networks – our clinicians have actively participated in all meetings arranged to date. This is where the clinical care pathways of our patients are considered and the network will shape and improve services.

"We secured 99% of our CQUIN targets generating £892,138 of income. For our local dental schemes, we achieved 100% our local targets generating £241,243 of income."

Registration with the Care Quality Commission

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

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

The CQC has not taken enforcement action against QVH during 2017/18 and QVH has not participated in any special reviews or investigations by the CQC during this reporting period.

The CQC conducted a routine announced inspection of QVH on 10-14 November 2015 and a further unannounced spot check on 23 November 2015.

"When we inspected QVH, we saw some excellent practice and outstanding care. We saw that staff were incredibly caring and compassionate with patients, and patients praised the care they received."

Alan Thorne, CQC Head of Hospital Inspections (South East).

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

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

The recommendations and findings from the CQC report were transferred into a continuous improvement action plan. The action plan contained improvements with a primary focus on the critical care findings. Progress against these actions was monitored at the quality and governance committee.

The CQC highlighted three areas where QVH needed to take action: that all medication in theatres is stored appropriately, out of hours medical cover is sufficient to meet the needs of the patients, and all clinical staff have had training in the Mental Capacity Act.

A comprehensive improvement action plan was drawn up to address these areas, and other areas identified by the inspection team which could be improved. Monitoring of the action plan was incorporated into the Trust's quality and safety reporting structure.

All actions have now been closed or form part of other ongoing workstreams.

Compliance in Practice inspections

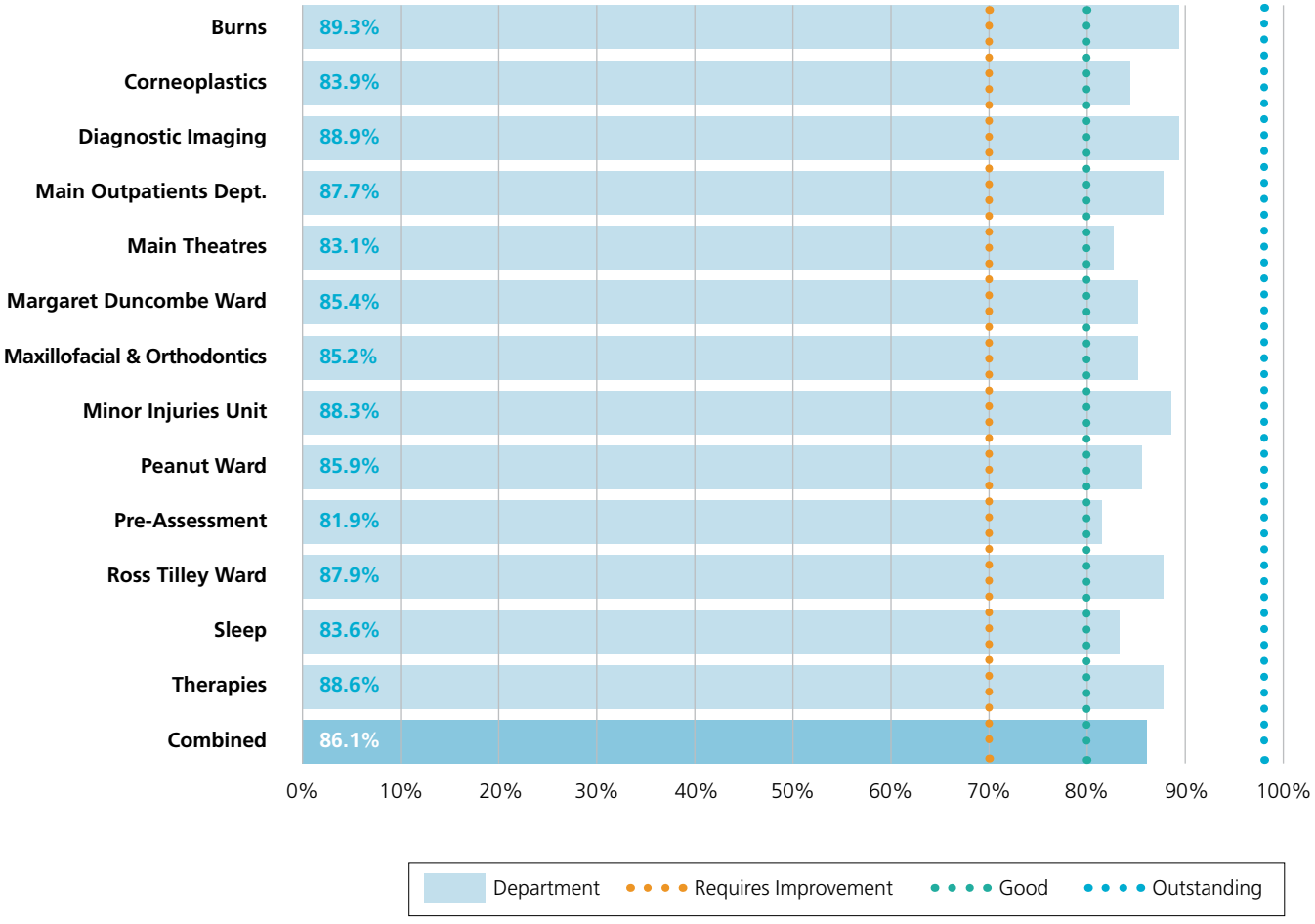
QVH continues to utilise the Compliance in Practice inspection process as a quality improvement initiative within the Trust.

Inspectors are recruited from the QVH staff base and include a variety of clinical and non-clinical stakeholders, as well as members of the board and council of governors. Inspection teams are then allocated to inspect one of thirteen clinical areas that are each visited on a quarterly basis.

The structure of the inspections reflects the enquiry lines pursued by the CQC and, as such, assists in enabling the Trust to maintain, and endeavour to improve, its current inspection rating. Newly devised action plans are completed by department leads following each inspection to remedy any areas of poor performance or inconsistencies identified.

Inspection standards are linked to the CQC rating system and all areas are reaching a compliance rating of 'Good'.

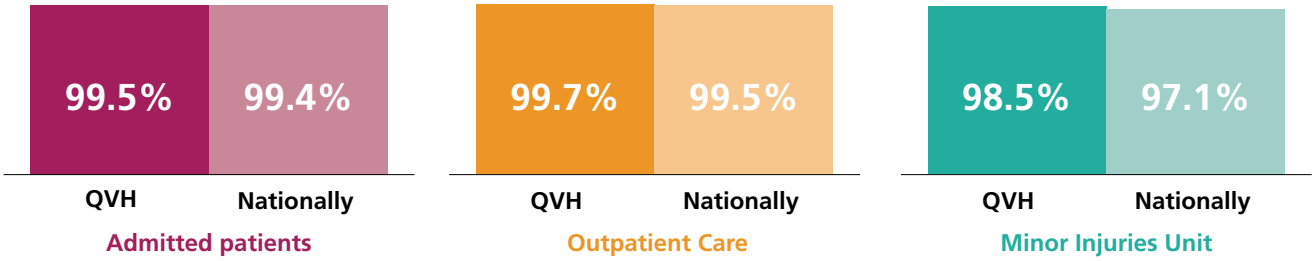
Compliance in practice inspection ratings



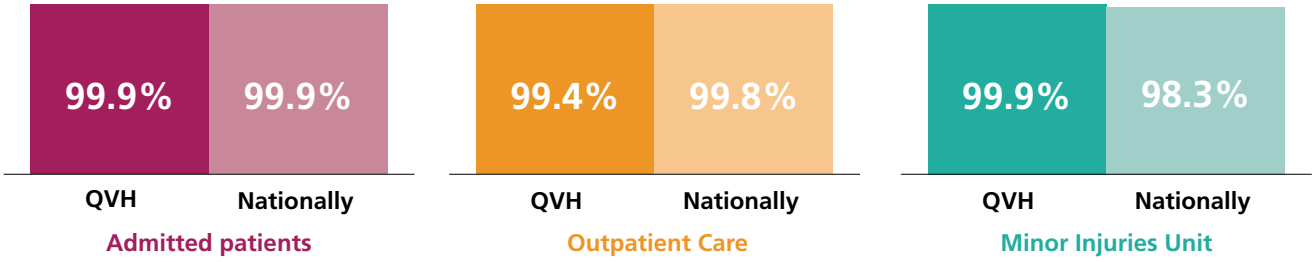
Hospital episode statistics

QVH submitted records during 2017/18 to the Secondary Uses Service for inclusion in the hospital episode statistics.

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



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



Source: The figures are aggregates of the QVH entries taken directly from the SUS data quality dashboard provider view, based on the provisional April - December 2017 SUS data at the month 8 inclusion date.

Information governance assessment

Responsibility for the information governance agenda is delegated from the chief executive to the senior information risk owner (SIRO), who is the director of finance and the caldicott guardian who is the director of nursing and quality.

The SIRO is responsible for ensuring that information risk management processes are in place and are operating effectively. The Caldicott Guardian is responsible for ensuring the confidentiality of patient information and appropriate information sharing.

The agenda for this area of work increases each year both in its scope and detail. Privacy and confidentiality are integral at every stage of the patient pathway and our business processes.

In 2017/18, the Trust began implementing data security standards that underpinned its cyber security strategy. We achieved the Cyber Essentials accreditation in February 2018 and Cyber Essentials Plus in March 2018.

A particular focus has been on readiness for the new data protection legislation that will be introduced in May 2018. This will be more stringent and prescriptive on how personal data must be managed.

Compliance against the law and central guidance is assessed by the online information governance toolkit. Information governance toolkit assessments must be completed and published by all bodies that process the personal confidential data of citizens who access health and adult social care services. QVH's information governance toolkit overall score for 2017/18 was 79% and graded satisfactory.

Improving data quality

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

Using the results of regular studies of data flows and processes informed by routine independent audits and benefiting from the increased transparency and visibility of data issues provided by an integrated data warehouse, problems have been identified and solutions put in place to improve the consistency and quality of data collected.

New reporting structures have allowed greater automation, reducing the risk of human error whilst liberating experienced staff to address more complex data quality issues.

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

QVH's business intelligence team has engaged with all disciplines within the Trust to improve processes around data collection and to design standard processes that help to improve consistency while reducing opportunity for variation.

In 2018/19 QVH will be continuing to progress the data quality agenda:

- build and apply a library of integrated standard operating procedures for data collection
- with support from external experts, enhance existing data flows to be best of breed
- continue to raise the profile and importance of good data at all levels within the Trust
- build an audit trail as part of the production process which will allow for responsive alerts which will flag data quality issues needing attention.

Payment by results and clinical coding

In 2017/18 an external coding consultancy carried out a clinical coding audit at QVH. Compliance rates for the clinical coding of diagnoses and treatment were:

- primary diagnoses 98/%
- secondary diagnoses 97%
- primary procedures 98%
- secondary procedures 99%.

The following services were reviewed within the sample:

- children's and adolescent services
- dentistry and orthodontics
- ear, nose and throat
- head and neck cancer services
- oral and maxillofacial surgery
- hands
- ophthalmology
- plastic surgery
- breast surgery
- skin cancer services.

Learning from deaths

All NHS trusts are required to report on learning from deaths using prescribed wording which enables readers to compare performance across organisations.

During 2017/18 four QVH patients died. This is shown below as deaths which occurred in each quarter of this reporting period

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Number of deaths	1	0	0	3

During 2017/18 four case record reviews and no investigations have been carried out in relation to four deaths which have occurred at QVH. All patients who died on site were reviewed using the Structured Judgement Case Note Review.

In no cases was a death subjected to both a case records review and an investigation.

No patients representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

All deaths which occur within 30 days off site are subject to a preliminary review with escalation and investigation as part of the risk management framework.

Reporting of national core quality indicators

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

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

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

Mortality

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

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

In-hospital mortality

2013/14	2014/15	2015/16	2016/17	2017/18
0.01%	0.02%	0.03%	0.005%	0.02%

Source: QVH information system

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

The National Quality Board published a framework in March 2017 around identifying, reporting investigating and learning from deaths, along with NHS Improvement guidance regarding the requirement that all trusts develop a policy by September 2017, 'Responding to and learning from deaths'. This policy was written by the Trust's head of risk and ratified for use in September 2017.

Of the eight recommendations, one of the key areas was around reviews and investigations and the medical director and head of risk attended Royal College of Physicians 'structured judgement review' training which has been rolled out for use within the Trust.

The Trust has also rolled out investigation training sessions to assist key staff in undertaking investigations and producing reports of a high quality.

Emergency readmission within 28 days of discharge

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

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

	Discharges				Readmissions				28 days readmission rate			
	14/15	15/16	16/17	17/18	14/15	15/16	16/17	17/18	14/15	15/16	16/17	17/18
Under 16	2,164	2,238	2,265	1,749	41	60	41	61	1.89%	2.68%	1.81%	3.49%
16 +	16,174	17,049	18,234	13,796	297	324	369	362	1.84%	1.90%	2.02%	2.62%
Total	18,338	19,287	20,499	15,545	338	384	410	423	1.80%	1.90%	2.00%	2.70%

Source: QVH information system

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

Clinical indicators such as readmissions provide broad indicators of the quality of care and enable us to examine trends over time and identify any areas requiring extra scrutiny.

National core quality indicators

Infection control – hand hygiene compliance

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

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

Hand hygiene (washing or alcohol gel use)

Target	13/14	14/15	15/16	16/17	17/18
95%	99%	98.4%	99.1%	99.4%	99.2%

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

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

> "We are committed to keeping patients safe through continuous vigilance and maintenance of high standards."

Infection control – Clostridium difficile cases

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

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

Clostridium difficile rates

	2013/14	2014/15	2015/16	2016/17	2017/18
Trust apportioned cases	1	1	1	2	Not published, expected June 2018
Total bed-days	18,362	14,778	14,406	14,278	
Rate per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	5.4	6.8	6.7*	14	
National average rate for acute specialist trusts	14.7*	15*	14.9*	13.2	
Best performing trust	0	0	0	0	
Worse performing trust	81.8*	115*	113.2*	147.5	

Source: Health and Social Care Information Centre data May 2017

https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data

*This data has been updated from the 2016/17 quality report to reflect a change in reporting methodology

QVH continues to maintain its low infection rate through surveillance supported by robust policies and procedures linked to evidence-based practice and NICE guidance. Infection rates are routinely monitored through the Trust's infection prevention and control group and quality and governance committee. QVH strives to meet the challenging target of zero cases per annum. Root cause analysis in previous cases has shown correct antimicrobial prescribing and clinical documentation to be an issue. Robust antimicrobial monitoring and prescribing will help towards meeting this target.

Reporting of patient safety incidents

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

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

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

Patient safety incidents

	2015/16		2016/17		2017/18
	01/04/15 - 30/09/15	**01/10/15 - 31/03/16**	**01/04/16 - 30/09/16**	**01/10/16 - 31/03/17**	**01/04/17 - 30/09/17**
Total reported patient safety incidents	381	492	412	295	294
Incident reporting rate per 1,000 spells	52	69	57	42	41
Incidents causing severe harm or death	0	1	2	1	0
Percentage of incidents causing severe harm or death	0%	0.2%	0.5%	0.3	0
Acute specialist trust benchmarks	**01/04/2015 - 30/09/2015** (per 1,000 bed days)	**01/10/2015 - 31/03/2016** (per 1,000 bed days)	**01/04/2016 - 30/09/2016** (per 1,000 bed days)	**01/10/2016 - 31/03/2017** (per 1,000 bed days)	**01/04/2017 - 30/09/2017** (per 1,000 bed days)
Lowest national incident reporting rate	15.9	16.05	16.34	13.67	14.82
Highest national incident reporting rate	104.45	141.94	150.63	149.7	174.59
Lowest national % incidents causing severe harm	0%	0%	0%	0%	0%
Lowest national % incidents causing death	0%	0%	0%	0%	0%
Highest national % incidents causing severe harm	0.6%	0.4%	0.3%	1.4%	1.6%
Highest national % incidents causing death	0.8%	0.2%	0.3%	0.5%	0.2%
Average national % of incidents causing severe harm	0.1%	0.1%	0.1%	0.1%	0.2%
Average national % of incidents causing death	0%	0%	0%	0.1%	0%

Source: QVH data from Datix and benchmarking data from NRLS data workbooks

QVH encourages all staff to report incidents as soon as they occur. During 2018/19 work will continue to support staff with timely investigations, reducing the length of time taken to complete and ensuring any identified learning can be shared promptly.

Improved reporting of patient safety incidents to NRLS and NHS England continue to be a priority within the Trust.

In 2017/18 the council of governors locally selected indicator was medicines prescribing errors; the performance for 2017/18 was 90.

WHO safe surgery checklist

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

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

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

Use of the WHO Safe Surgery checklist

	13/14	14/15	15/16	16/17*	17/18
Sign in	98%	100%	99.58%	97%	98%
Time out	96%	100%	98.05%	98%	99%
Sign out	82%	100%	92.88%	95%	95%
	Target 100%				

Source: Monthly internal audit
* Audit not undertaken in March 2017

Patient safety is paramount at QVH. A whole-team safety briefing with surgical, anaesthetic and nursing staff occurs before the theatre lists begin. This improves communication, teamwork and patient safety in the operating theatre and is embedded in routine practice. A theatre action plan had been developed to improve the quality and effectiveness of the WHO checklist and help ensure Never Events do not occur.

The WHO Safer Surgery checklist forms the patient safety quality priority for 2018/19.

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

Venous thromboembolism – initial assessment for risk of VTE performed

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

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

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

VTE assessment rate (%)

	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
QVH	100	100	100	100	93.9	97.5	91.87	93.04	90.9	91.8	93.53	94.42	99.3	96.42
National average	96.10	96.20	96.00	96.00	96.00	95.90	95.50	95.53	95.73	95.51	95.64	95.53	95.20	95.25
National average specialist trusts	97.40	97.30	97.40	98.00	98.70	97.70	97.23	97.53	97.53	97.40	97.65	97.44	97.58	97.58
Best performing specialist trust	99.50	99.10	99.90	100	99.90	100	100	100	99.97	99.96	100	99.96	99.97	99.94
Worst performing specialist trust	94.60	93.30	94.30	95.00	93.90	95.10	91.87	93.04	90.96	82.68	90.67	94.42	95.56	95.24

Source: QVH information system

We continuously strive to minimise VTE as one of the most common causes of largely preventable post-operative morbidity and mortality. We are committed to ensuring that those patients undergoing surgery are risk assessed and the necessary precautions are provided, including compression stockings and low molecular weight heparin.

QVH undertakes the NHS 'safety thermometer' on a monthly basis in all inpatient areas. It provides the Trust with a rate of harm-free patient care and includes the assessment of patients for VTE risk on admission and re-assessment after 24 hours following admission or surgical intervention.

Work will continue into 2018/19 to ensure that QVH maintains its 95% target for VTE assessments within 24 hours of admission. Performance against this target is measured on a monthly basis using the Trust-wide performance dashboards.

Pressure ulcers

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

- QVH has a robust process for collating the incidence of pressure ulcers
- A root cause analysis (RCA) is undertaken for all pressure damage grade two and above
- All pressure damage RCAs are presented internally to share learning
- Recent learning from some incidents has led to change in practice in theatres
- QVH has created a new tissue viability nurse post which has been recruited to
- A baseline audit has been completed and an education package is being developed to tailor to different area's needs.

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

Target	13/14	14/15	15/16	16/17	17.8
0	0.5 (total = 8)	0.6 (total = 11)	0.9 (total = 17)	0.5 (total = 10)	0.4 (total = 9)

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

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

"A baseline audit has been completed and an education package is being developed to tailor to different area's needs."

Same sex accommodation

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

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

Failure to deliver single sex accommodation (occasions)

Target	13/14	14/15	15/16	16/17	17/18
0	0	0	0	0	0

QVH is committed to providing every patient with same sex accommodation to ensure that we safeguard their privacy and dignity when they are often at their most vulnerable. We have maintained segregated accommodation during 2017/18 through the use of single rooms and the appropriate planning of patient admissions.

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

NHS friends and family test – patients

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

QVH has a process for collating NHS friends and family test data across all areas of the Trust

Data on inpatient and outpatient services is collated internally and submitted to the Department of Health on a monthly basis and published by NHS England

Patient responses are collected from cards, text messages and integrated voice messaging

Response rates and patient responses for 'extremely likely/likely to recommend' and 'unlikely/extremely unlikely to recommend' are compared with our specialist trust peers

The results are published on the QVH website and shared with staff on a monthly basis.

Results are presented to the board, quality and governance committee and patient experience group on a regular basis.

NHS friends and family test scores (from patients)

	Minor injuries unit			Acute inpatients			Outpatients		
	2015/16	2016/17	2017/18	2015/16	2016/17	2017/18	2015/16	2016/17	2017/18
Percentage extremely likely/likely to recommend	94%	95%	96%	99%	98%	98%	94%	94%	94%
Percentage unlikely/extremely unlikely to recommend	3%	2%	2%	0%	0%	0%	2%	2%	2%
Response rate	25%	27%	24%	51%	46%	43%	18%	17%	16%

Source: QVH information system

Staff at QVH work hard to ensure patients receive the best care and patient experience through our services. Comments received electronically are reviewed on a daily basis so that we are able to respond to potential issues in a timely manner. Friends and family test response rates are amongst the highest in the South of England.

Responses and comments are broken down into weekday and weekend feedback to help inform our continued implementation of seven day services at QVH.

We have developed a patient experience programme that allows patients to provide their feedback in real-time through the inpatient surveys or social media; or at a later date through NHS Choices' Care Opinion, postal surveys, focus groups, face to face engagement and of course PALS and complaints.

"Staff at QVH work hard to ensure patients receive the best care and patient experience through our services. Comments received electronically are reviewed on a daily basis."

Complaints

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

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

Complaints per 1,000 spells (all attendances)

Target	13/14	14/15	15/16	16/17	17/18
0	0.4	0.4	0.3	0.3	0.27

Complaints per 1,000 spells (Inpatients)

Target	13/14	14/15	15/16	16/17	17/18
0	4.7	4.1	2.8	2.6	2.5

Source: Continuous internal audit

We understand that every concern or complaint is an opportunity to learn and make improvements in the areas that patients, their relatives and carers say matter most to them. We understand that handling concerns and complaints effectively matters for people who use our services who deserve an explanation when things go wrong and want to know that a change has been made to prevent something similar happening to anyone else.

It is always our aim to address concerns and resolve problems quickly and effectively at the point of care to ensure the satisfaction of all involved. their complaint has made a difference is our priority. Effective concerns and complaint handling is an important part of ensuring that people receive high quality care.

We take all negative feedback very seriously and our chief executive sees all complaints when they arrive and reviews all responses personally before they are sent. Complaints handling and any trends or themes identified from them are shared and discussed regularly by the executive team and the board of directors, and are reviewed within each of the divisions across the organisation on a monthly basis.

During 2017/18, two complaints were referred to the Parliamentary Health Service Ombudsman, and are still under review.

Staff survey

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

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

Studies have shown that staff who are empowered, engaged and well supported provide better patient care. At QVH we are very proud of the positive feedback that we receive from patients and despite a challenging level of vacancies in some areas, we continue to make sure our staff receive appropriate professional development, have opportunities to improve their health and wellbeing, and have satisfying roles where they know what they contribute to QVH being able to provide outstanding care.

In the 2017 staff survey our staff engagement score dropped slightly to 3.85, down from 3.87 in 2016. The average for specialist trusts in the QVH comparator group is 3.95, down from 3.98 in 2016. The overall engagement score for acute trusts in 2017 was 3.78.

Changes in the external NHS environment have continued to impact on QVH in the last 12 months and the Trust has experienced nursing retention challenges, particularly in theatres, leading to a higher usage of temporary staff.

Almost 55% of the total workforce responded to the survey, a similar number to 2016. Survey results have also shown staff continuing to recommend QVH as a place to receive treatment at 88%, this is a slight reduction from 91% in 2016. There continues to be a decline in general job satisfaction, 57% in 2017 compared to 62% in 2016, compared to 72% across the benchmark group.

Staff recommending as a place to receive treatment

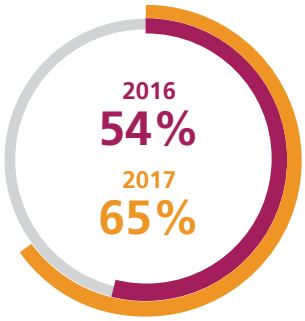
	13/14	14/15	15/16	16/17	17/18
Percentage extremely likely/likely to recommend	94%	91%	93%	91%	88%
Average (median) for acute specialist trusts	86%	87%	91%	88%	89%
Highest scoring specialist trust	94%	93%	93%	95%	93%
Lowest scoring specialist trust	67%	73%	80%	76%	79%

*source www.nhsstaffsurveys.com

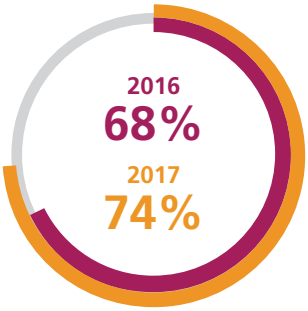
Of the 88 questions in the survey the Trust scored significantly better on 5 questions, worse on 1, and no significant difference in the remaining 82 questions.

The areas of improvement were:

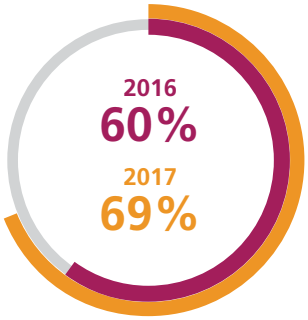
Immediate manager gives clear feedback on my work



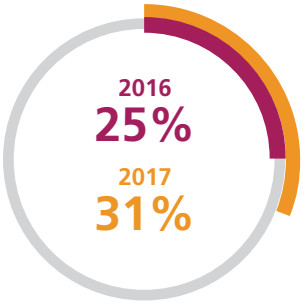
Immediate manager is supportive in personal crisis



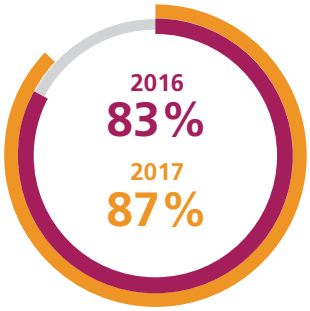
Immediate manager takes positive interest in my well being



Senior managers try to involve staff in important decisions



Had appraisal/KSF review in last 12 months



Source: NHS staff survey

There was a decline in staff feeling that they were able to provide the care that they aspire to, down to 68% in 2017 from 74% in 2016. This is felt to be attributable to pressure from additional activity and areas of staff shortages as well as a number of non-clinical staff responding to this question.

Staff experiencing harassment, bullying or abuse

Staff experiencing harassment, bullying or abuse

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

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

	2016	2017	2017 average for specialist trusts
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months (lower the better)	24%	22%	23%
Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse (higher the better)	47%	50%	47%
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months (lower the better)	23%	25%	21%

Source: NHS staff survey

QVH has a zero tolerance approach to all forms of bullying and harassment and this is reflected in the results amongst staff. We will focus further on the behaviour of patients and the public over the next year.

QVH has a clear policy and process for managing and dealing with concerns (whistleblowing) raised by staff which were reviewed further to the election of a Freedom to Speak Up Guardian in April 2017. Over the next 12 months, we will continue to deliver training for all staff and develop managers' skills in how to manage allegations of bullying and harassment. ACAS has delivered a series of workshops on this topic which has now been incorporated into our management and leadership programme to provide ongoing support for managers.

We have seen an improvement in the number of staff reporting that they have had an appraisal; 87% in 2017 versus 82% in 2016. We will be focussing over the next year on the quality of these appraisals and how effective they are in supporting the development of individuals.

Staff survey

Equal opportunities for career progression

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

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- Differences are reviewed and, where possible, action taken to address issues identified
- All staff are encouraged to complete the survey and the response rates are above average.

	2016	2017	2017 average for specialist trusts
Percentage of staff reporting equal opportunities for career progression and promotion (higher the better)	86%	87%	88%
Percentage of staff experiencing discrimination at work in the last 12 months (lower the better)	12%	10%	9%

Source: NHS staff survey

QVH currently delivers a high level of statutory and mandatory training, and compliance levels are reviewed by business units each month. The board reportable compliance target is 95%, and 98% of staff who responded to the staff survey state they have accessed mandatory training in the last 12 months. Over the next 12 months we will continue to deliver statutory and mandatory training via a range of interventions. We are also part of the streamlining project in our sustainability and transformation partnership (STP) area to support easy passporting of this training across NHS organisations saving time and resources and improving the experience of the individual.

QVH also provides training to support personal development, management and leadership development. We will continue to promote apprenticeship opportunities to new and existing staff, and we expect to increase the numbers of apprenticeships across the Trust in 2018.

Wellbeing

In 2017/18 the Trust updated the appraisal toolkit to ensure that managers have a conversation with all staff in relation to their general health and wellbeing.

QVH has a health and safety committee which regularly receives reports from across the Trust highlighting any risks and how they are being addressed. In addition, the human resources department provides quarterly information on the support provided to staff through our occupational health and employee assistance providers. Data on this is also included in workforce reports to the board and board sub-committees. Our occupational health service is provided by a neighbouring trust, Surrey and Sussex Healthcare Trust. We have seen a number of enhancements to the services including an improved triage service, improved reporting and record keeping, enhancements to key policies, improvements in health surveillance and access to support seven days a week.

We now contract directly for a more cost effective employee assistance service. This provides all staff with a range of personal and professional support including confidential counselling and legal advice for both work related and non-work issues; stress management; advice to staff on injuries at work; and a 24-hour employee assistance programme which provides comprehensive, round the clock phone advice for all staff including legal advice and access to an online well-being portal.

Workforce

The significant workforce challenges across the NHS impacted on the Trust during 2017/18. This has been demonstrated in the turnover of clinical staff, particularly nursing staff in theatres, critical care and paediatrics, and also reflected in the staff survey and staff friends and family feedback. The Trust is also aware that we have an ageing workforce with a relatively high proportion of staff who could retire in the near future.

NHS Employers and NHS Improvement have stated that workforce is the single biggest challenge and risk in the NHS nationally. In summer 2017 we were invited to participate in the NHS Improvement Retention Support Programme with the objective of improving staff retention in NHS trusts and bringing down the leaver rates.

The Trust Board agreed to an ambitious multi-faceted engagement and retention programme linked to a number of KPIs. Progress in delivering the various aspects of this programme has been well received in many areas by existing clinical staff, however attraction remains a challenge as all local trusts are targeting the same staff groups with similar incentives and in our geographical location we are disadvantaged by high cost of living and supplements offered by other trusts.

NHS Improvement national priority indicators

NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. It offers the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, NHS Improvement helps the NHS to meet its short-term challenges and secure its future.

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

QVH's 2017/18 performance against these indicators was:

			Performance		Quarterly trend			
		National priority indicator	Target	Annual	Q1	Q2	Q3	Q4
Safety	**Infection control**	C-Diff (Clostridium difficile) acquisitions	0	0	0	0	0	0
Experience	**Referral to treatment times**	% incomplete pathways less than 18 weeks RTT	92%	77.18%	90.03%	84.43%	80.49%	77.18%
	Minor Injuries Unit access	Attendees completing treatments and leaving within 4 hours in minor injuries unit	95%	99.71%	99.66%	99.80%	99.50%	99.88%
Effectiveness	**Cancer access – initial appointments**	Urgent cancer referral seen within 2 weeks wait	93%	92.59%	94.39%	91.94%	93.08%	90.4%
	Cancer access – initial treatments	% of cancer patients treated within 62 days of urgent GP referral	85%	74.4%	73.6%	71.1%	76.5%	77.3%
		% patients treated within 62 days from screening referral (Screening service not offered at QVH, all patients are on a shared pathway with other providers)	90%	77.8%	33.33%	50.00%	100%	N/A (no patients treated in this period)
		% treatment started within 31 days from decision to treat, first treatment	96%	94.2%	97.1%	95.7%	95.7%	86.6%
		% treatment started within 31 days from decision to treat, subsequent treatment	94%	90.5%	94.6%	95.3%	90.5%	82.6%

Source: QVH information system.

NHS Improvement national priority indicators

The Trust has struggled with both the 18-week referral to treatment (18RTT) and cancer targets. The main reasons for the underperformance in 18RTT are an increase in demand (particularly in maxillofacial services) against a significant vacancy factor in theatre nursing and a low level of validation resource. The Trust is working with commissioners to manage and balance demand and capacity, has invested in additional validators, has developed a range of recruitment and retention incentives, has theatre and access and appointments productivity programmes and is working with NHS Improvement on both 18RTT and cancer improvements. Late referrals from other trusts and complex pathways due to the specialist nature of our work also impacts upon cancer waiting times. As a result of these challenges, the Trust has had 52 week breaches. The Trust is working collaboratively with NHS Improvement to improve performance on cancer 62 day target.

RTT 18 Open Pathways (%)

Target	Q1	Q2	Q3	Q4	2017/18 end of year position
92%	90.03	84.43	80.49	77.18	77.18%

Cancer 62 day:

Target	Q1	Q2	Q3	Q4	2017/18 end of year position
85%	73.6	71.1	76.5	77.3	74.4%

Source: Open Exeter

Operations cancelled by the hospital for non-clinical reasons

During 2017/18 over 15,000 surgical cases passed through our theatres and every effort is made to minimise cancelled operations, as shown in the figures below. However, cancellations are unavoidable on occasion, for example when there are more urgent cases that require a theatre. To minimise cancellations, all patients at risk of cancellation are now escalated to the daily business manager. This ensures that all options are considered and cancellations only occur when all other routes have been explored.

	How data is collected	Target	2014/15	2015/16	2016/17	2017/18
Cancer - 62 day wait from referral to first definitive treatment	Data collected monthly and reported quarterly. Performance includes shared care with other providers	85%	87.0%	82.34%	82.45%	74.43%
18 weeks - incomplete pathways	Data collected from monthly snapshots	92%		92.91%	91.5%	77.18%
Diagnostic waiting times	Waiting times for routine ultrasound access	Maximum 6 week wait			2-3 weeks	3-4 weeks
Minor injuries unit - patients leaving without being seen	Data collected from PAS in the minor injuries unit	5%	1.90%	2.38%	1.62%	1.30%
Operations cancelled on the day of surgery for non-clinical reasons and not rebooked within 28 days	Data collected from PAS and theatre systems	0	3	4	4	14
Urgent operations cancelled for non-clinical reasons for a second or subsequent time	Data collected from PAS and theatre systems	0	3	3	0	0

Clinical effectiveness indicators

In 2017/18 QVH's clinical specialities continued to be amongst the most experienced and effective in the world.

Head and neck
Survival after 30 days

117 Major cases

100% QVH success rate
98.3% National benchmark

Orthodontics
Improvement in tooth position

17,157 Orthodontic procedures*

99% QVH success rate
70% National benchmark

Breasts
Treatment following cancer

277 Immediate breast reconstruction using free tissue transfer

99.3% QVH success rate
98% National success rate

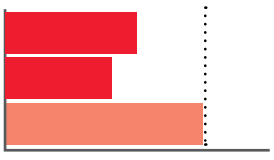
Eyes
Achieved better than 6/12 vision following a cataract procedure

1,522

100% QVH success rate
96% National benchmark

Burns
Average burn wound healing time

1,182 Adult
907 Paediatric



17 days adults
11 days paediatric
‹ 11 days established benchmark

Skin cancer
Melanomas completely removed

259 Melanomas removed

94.6% QVH complete excision rate
75% NICE national benchmark

Hands
Improvement in function after surgery

1,495 Procedures

18.46 points QVH average (for major elective)
18 points benchmark

*Data collection method updated from 2016/17

Services we provide

Anaesthetics

The anaesthetic department at QVH includes 18 consultant anaesthetists, five associate and trust grade specialists and eight senior anaesthetic trainees with responsibilities to patients before, during, and after surgery. We provide pre-operative assessment, anaesthesia, pain and critical care services in the Trust.

The acute pain team consists of two consultants and two part time specialist nurses and manages regional anaesthetic blocks, epidurals and pump controlled analgesia for postoperative analgesia.

The preassessment department is staffed by a team of six nurses who work with over 14,000 elective cases a year. About 70% are seen in the preassessment department either on the day of their surgical outpatients appointment or by a separate clinic appointment prior to their surgery. About 30% are triaged by phone after filling in a paper or electronic questionnaire. Approximately 5% of all patients also see an anaesthetist at one of the four anaesthetic clinics a week. The preassessment clinics help to make sure patients are fully prepared for surgery, reducing the need to cancel on the day of surgery. The national gold standard is to have an on day cancelation rate of no more than 5%. Despite our large geographical catchment area and the range of ages and conditions we treat, the quality of our preassessment services help us have an on day cancelation rate much lower than this.

QVH is a specialist centre for hand trauma and elective surgery on the hand and upper limb. A large proportion of this surgery is carried out under regional anaesthesia alone, avoiding the need for a general anaesthetic, or in addition to sedation or general anaesthesia, providing excellent post-operative pain relief for these procedures. The anaesthetists are responsible for siting the regional anaesthetic block and there is a dedicated block room in theatres for this purpose.

In 2017/18 anaesthetists performed 1,200 upper limb regional anaesthetic blocks for upper limb surgery. An audit carried out by the anaesthetic department in October 2017, which involved contacting patients 24-48 hours following their upper limb operation under a regional anaesthetic alone, found that 96% of the patients were satisfied with the anaesthetic technique.

The anaesthetic department is active in research and we have a research fellow and dedicated research nurse. Recent projects include looking at how facial expressions change in response to painful stimuli. This was a laboratory based study carried out in conjunction with the psychology department at the University of Brighton and the facial palsy surgeons at the QVH. A pilot study to assess the feasibility of using inhaled methoxyflurane for burns dressings assessment and treatment was completed and methoxyflurane is now in use for burns procedural pain relief.

QVH also participated in multi-centre studies coordinated by the National Institute of Academic Anaesthesia. These include the SNAP-1, SNAP-2 and the PQIP studies. We have recruited in excess of 100 patients into these studies and have made amendments to the national PQIP protocol to include burns and plastic surgery patients.

Facial paralysis

QVH has the UK's first, largest and currently, most advanced multidisciplinary facial paralysis service. Now a world-class service, the multidisciplinary service at QVH was set up in 2007 with the main objective of establishing holistic care for patients suffering from facial paralysis. Patients can be seen on the same day, in a single location, by a consultant plastic surgeon, extended scope practitioner physiotherapist/speech and language therapist, consultant ophthalmologist and consultant psychotherapist. This was built on the legacy of Redmond McLaughlin, QVH consultant plastic surgeon from the 1940s, the global pioneer in the management of facial paralysis.

Across the UK, healthcare for patients with facial paralysis varies, with many patients receiving little or no treatment. Services tend to be fragmented and frequently do not offer a combination of therapy and surgical treatment options in one location. As facial palsy causes physical, functional, social and psychological disability a comprehensive multidisciplinary approach is required to address these complex issues. Based on this need, QVH clinicians led by Charles Nduka, also founded the national charity Facial Palsy UK which supports people living with facial palsy and their families.

The therapy team, in conjunction with other specialist clinicians, founded Facial Therapy Specialists UK, a special interest group dedicated to professional education, driving improvements in standards of care and supporting research. The QVH service has raised the awareness of clinicians and the public that treatment of facial paralysis is essential and beneficial. Treatment is not just cosmetic but rather the emphasis is on restoring the important functions of eye protection, eating, drinking, speech and emotional expression.

Moving forwards, QVH has now embarked on advanced facial palsy treatments including chimeric vascularised nerve grafts, surgery for severe synkinesis, corneal neurotisation and is at the forefront of advances in the management of cranial nerve disorders. The philosophy of the QVH team is 'getting it right first time'. This emphasises the benefits of having early and effective holistic treatment for facial paralysis.

QVH is now working with academic and technical partners to develop 'smart specs' for people suffering from facial paralysis. Miniaturised sensors in the frames of the glasses measure facial symmetry by tracking the movement of muscles, and the intensity of those movements, giving feedback through a smart phone or tablet. This was showcased on the BBC and trials are under way. This innovation could transform the ability of both clinicians and patients to monitor their progress, as well as significantly improve recovery as patients are more motivated to practice facial movements.

Reconstructive breast surgery

A flap is the name given to a block of tissue that is transferred with its own blood supply. Advantages of flap reconstruction are that flaps tend to be soft, warm and results often improve with time. Flaps can be moved to the chest from distant sites such as the abdomen or thighs, by cutting the tissue free from the body with its blood-supply, and using a microscope to re-attach the blood-supply from this tissue into vessels on the chest to keep it alive.

QVH is a major centre for this type of micro-vascular reconstruction, known as free-flap breast reconstruction. Abdominal-based free-flaps are known as free DIEP (Deep Inferior Epigastric Perforator) flaps or MS-TRAM (Muscle-sparing Transverse Rectus Abdominis Myocutaneous) flaps. Medial thigh-based flaps are known as free TUG (Transverse Upper Gracilis) flaps.

Reconstructive surgery can be performed either at the same time as a mastectomy for breast cancer (immediate breast reconstruction) or after all treatment has been completed (delayed breast reconstruction). These procedures can also be used to improve outcomes for patients who have run into difficulties following other types of reconstruction, and are also the treatment of choice for breast reconstruction following radiotherapy.

We are managing an increasing demand for bilateral reconstruction on the same day as a risk-reducing mastectomy for patients who have a genetic predisposition to breast cancer, such as the BRCA gene. This is likely to further increase due to high profile media attention and improved genetic screening techniques.

With increasing frequency, free bi-pedicled DIEP flaps (where the vessels from both sides of the abdomen are re-attached to chest vessels), and two-in-one TUG flaps (placing both TUG flaps into one breast), are used in complex reconstructive situations to enable larger reconstructions to be successfully performed.

Our team of consultants and specialist breast reconstruction nurses provide a wide range of other reconstructive procedures and also undertake reconstructive surgery to correct breast asymmetry, breast reduction and, if funding can be obtained, congenital breast shape deformity. We run regular breast reconstruction multidisciplinary meetings and liaise closely with all referring units.

Breast reconstruction after mastectomy using free tissue transfer – flap survival

The gold standard for breast reconstruction after a mastectomy is widely thought to be a 'free flap' reconstruction using micro-vascular techniques to take tissue, usually from the abdomen, or thighs and use it to form a new breast. This technique has high patient satisfaction and longevity. It is important we not only monitor our success in terms of clinical outcome but also how the woman feels throughout her reconstructive journey. This is called a patient reported outcome (PROM).

Outcomes include length of stay, emergency returns to theatre, readmissions to hospital, patient feedback. Any reconstructive failures are reviewed in our monthly breast team meetings to determine what we can learn and improve the service we provide for our patients.

The numbers of immediate breast reconstruction (at time of mastectomy) surgery patients has increased from 21% in 2013/14, to 49% in 2017/18. In the last year 277 free flaps were performed with a 0.7% failure rate. We are predicting that the number of immediate reconstructions will again rise over the next year and have again increased our capacity for immediate breast reconstruction to ensure the patient trajectory is smooth and within the cancer target dates.

Breast reconstruction after mastectomy using free tissue transfer - flap survival

Target	Benchmark	2013/14	2014/15	2015/16	2016/17	2017/18
100%	95-98% (published literature); 98% (BAPRAS 2009)	98.94%	100%	99.6%	100%	99.3%

BAPRAS: British Association of Plastic Reconstructive and aesthetic surgeons

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

Since the introduction of enhanced recovery after surgery, the post-operative length of stay has decreased from 5 to 3.9 days. A study is currently underway to look at factors that may predict early discharge; free-DIEP and free-TUG patients are often discharged home after a two-night inpatient stay at QVH.

Services we provide

Hand surgery

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

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

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

Going forward, the department is looking to expand the trauma service to include a weekly fracture clinic at QVH. Provision will include direct consultant involvement and supervision to increase their presence and oversight in day to day trauma care.

The QVH hand surgery team continues to collaborate in national research studies on Dupuytren's disease and metacarpal fracture management. In addition, weekly hand training sessions continue for the junior doctors.

	2013	2014	2015	2016	2017	2018 Jan - Mar
Total elective hand procedures	1,422	1,893	1,881	1,750	1,495	253
Total trauma cases	2,384	3,084	2,972	3,042	2,824	253
Total new outpatient appointments	4,380	5,897	5,780	5,444	5,594	813

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

A high score reflects greater difficulty in carrying out normal hand functions. A reduction in that score shows the beneficial effect of treatment delivered by the multidisciplinary hand team (primarily physiotherapy, occupational therapy, nurses, surgeons and other medical staff) often over a prolonged treatment episode. A decrease of 18 or more indicates a significant clinical improvement in the ability to use the hand. At QVH we achieve above this and measuring outcomes enables us to validate and improve the overall quality of the service.

Effective clinical outcomes

	Target	2013/14	2014/15	2015/16	2016/17	2017/18
QuickDASH change conservative (hands)	A decrease of 18 or more	N/A	19.29	15.16	20.4	21.07
QuickDASH change surgery elective (hands)		N/A	22.48	19.18	18.33	18.46
QuickDASH change surgery trauma (hands)		N/A	38.97	31.54	33.5	37.91

Burns service

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

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

In 2017, the QVH burns service accepted:

- 1,182 adult (>16 years of age) new referrals which was a 6.5% increase in referrals
  - of which 96 needed inpatient care
- 907 paediatric (<16 years of age) new referrals which was a 21.35% increase in referrals
  - of which 20 required inpatient care.

QVH's paediatric ward provides inpatient and day case paediatric

services. Children who require critical care are referred to paediatric burns services within the London and South East England burn network that have the appropriate facilities.

In 2017 there were no adult or paediatric mortalities. All patients are discussed at weekly governance meetings in addition to daily ward rounds so that any learning points can be identified. If further review is required, the patient's case is discussed at a joint hospital governance meeting. All burns mortality cases are peer reviewed at the annual London and South East Burn Network audit meeting, with any outlier cases taken to the national burns mortality meeting. Key burns performance indicators are recorded and analysed through QVH's active participation in the international burns injury database (iBID) programme. This compares QVH's performance with that of all other English burns services in relation to set quality indicators.

Overall in 2017, QVH achieved better than the national average for the six valid dashboard indicators for both adult and paediatric burns care.

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

Burns healing in less than 21 days are less likely to be associated with poor long-term scars, although new treatments such as enzymatic debridement appear to increase healing times and avoid surgery. Evidence is now emerging that patients over the age of 65 have similar outcomes even if their healing time is extended to 31 days. However, a shorter burn healing time may reflect better quality of care through dressings, surgery and prevention of infection. Average healing time is expressed in term of median average.

Average time for burn wounds to heal

Target	2015	2016	2017
Paediatric (under 16 years) wound healing within 21 days	11 days	11 days	11 days (86%)
Adults over 65 years wound healing within 21 days	17 days	17 days	13 days (73%)
Adults over 65 years wound healing within 31 days	24 days	28 days	18 days (74%)

Length of stay

	2015	2016	2017
Paediatric (under 16 years)	2 days	2 days	2.40 days
Adults under 65 years	7 days	8 days	5.8 days
Adults over 65 years	14 days	14 days	8.7 days

Length of stay / percentage burn

	2016	2017
Paediatric (under 16 years)	1.25	1.48
Adults under 65 years	1.58	2.0
Adults over 65 years	1.66	6.5

Length of stay per percentage burn injury has increased significantly in our elderly population due to issues in discharging patients back to their local area or home. The burns service tries to work collaboratively with home services and local hospitals to facilitate transfer as soon as possible back to the patient's local area and initiates discharge planning for all patients admitted.

Skin cancer care and surgery

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

Complete excision rates in basal cell carcinoma

Target	2013/14	2014/15	2015/16	2016/17	2017/18
100%	92.5%	94.1%	96.8%	90.2%	93.5%

Basal cell carcinoma is the most common cancer in Europe, Australia and the USA. Management usually involves surgical excision, photodynamic therapy, 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. However, 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.

Services we provide

In 2017/18, 2687 basal cell carcinomas were removed by QVH and partners in the West Kent Dermatology Service.

Complete excision rates in malignant melanoma

Target	2013/14	2014/15	2015/16	2016/17	2017/18
QVH target 100% NICE guidance 75%	96.5%	96.1%	98.4%	94.4%	94.6%

Melanomas are excised with margins of healthy tissue around them, depending on the type, size and spread of tumour. These margins are set by national and local guidelines and each case is discussed by the multidisciplinary team. Total excision may not be possible because of the health of the patient or the size, position or spread of the tumour, and the team may recommend incomplete excision. In 2017/18, 259 melanomas were removed by QVH and partners in the West Kent Dermatology Service.

Corneoplastic and ophthalmology services

The corneoplastic unit, including our eye bank, is a high-profile and technologically advanced specialist centre for complex corneal problems, oculoplastic and glaucoma conditions. 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.

Specialist techniques provided in oculoplastic surgery including Mohs micrographic excision for eyelid tumour management, facial palsy rehabilitation, endoscopic dacryocystorhinostomy (DCR) for tear duct problems and modern orbital decompression techniques for thyroid eye disease.

The glaucoma team offers the full range of investigations and treatments and specialises in minimally invasive glaucoma surgery.

QVH performs routine and complex cataract surgery and takes referrals for general ophthalmology.

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

Target	Benchmark	2013/14	2014/15	2015/16	2016/17	2017/18
100%	96% (UK EPR)	With correction				
		100%	100%	100%	100%	100%
		Unaided				
		90%	92%	94%	82%	88%

Cataract patients with significant astigmatism now receive a specialist toric intraocular lens to correct this. QVH now has two new cataract surgery suites with state of the art implantation technology to improve placement accuracy.

Head and neck services

QVH is the specialist centre for major cancer and reconstructive surgery of the head and neck. Our head and neck services are recognised, both regionally and nationally, for the specialist expertise offered. The team has six oromaxillofacial surgeons and three ear, nose and throat surgeons. QVH is recognised by the Royal College of Surgeons as a centre for training interface fellows in advanced head and neck oncology surgery.

Total number of major head and neck cancer procedures

2013	2014	2015	2016	2017
65	106	126	119	117

In 2017 QVH treated 117 major cases with 30 day survival of 100% (against a national mortality benchmark of 98.3%) and a flap success rate of 96%.

We endeavour to give the highest quality of patient care and continually strive to improve in line with evidence-based best practice. QVH has therefore devised a rolling programme of multi-disciplinary training for doctors, nurses and allied health professionals treating our complex head and neck patients. It meets the recommendations of the National Confidential Enquiry into Patient Outcome and Death's 2014 report 'On the Right Trach?', a review of the care received by patients who underwent a tracheostomy. This training programme supports healthcare professionals to deliver enhanced recovery after head and neck surgery.

In 2017, the QVH locality group decided to align laryngectomy and dysphagia training together with the tracheostomy course to create a head and neck module to better fit our patient groups and growing service needs.

An audit of the first year of data from the enhanced recovery programme for head and neck cancer was completed and presented to the QVH governance meeting and at the British Association of Oral and Maxillofacial Surgeons conference in July 2017. This audit identified outcomes, adherence to the tool and a survey of health professionals using the tool. Hard outcomes demonstrated benefits to warrant continuation of the programme. Whilst adherence to the new documentation completion was variable, the opinion of all tool users was universally positive. Subsequent to rolling out our tool, we have been approached and visited by Southampton General Hospital in order for us to share our experiences, good and bad, to help them establish their own service. We have also been approached by the University College London Hospitals head and neck service with a view to us providing assistance in setting up their enhanced recovery programme.

QVH commenced head and neck sentinel node biopsy in September 2016 for early oral cancer requiring surgical management, supported by NICE clinical guideline NG36 published in February 2016. We completed our validation phase in nine months (national average one year) and have now rolled out the conventional sentinel node service. Other than the three long established providers in the UK (over five years), QVH is the first unit to commence conventional sentinel node biopsy for oral cancer. We are now part of the national mentor group and have helped set up the North West London head and neck unit. Our lead for setting up this service is also an external faculty member for UK training in sentinel node biopsy.

In order to deliver complete head and neck care, including palliative treatments to enhance quality of life, we have now developed electrochemotherapy patient pathways across West Kent and Sussex for treatment of palliative skin nodules. Before this, patients from Kent, Surrey and Sussex could only access this care in central London. A major provider of electrochemotherapy, South Tees Hospitals NHS Foundation Trust, is our mentor unit. We commenced the service in July 2017 and as awareness has grown referral rates are increasing. We have had a total of 14 referrals in seven months although due to the nature of advanced disease, not all patients have been suitable to have treatment. We are now working with plastic surgery colleagues to expand the practice beyond the head and neck.

In the summer of 2017, we held an event for head, neck and skin cancer patients to promote health and wellbeing. The event was well evaluated by attendees, particularly the sessions with clinicians talking about how to spot signs and symptoms of recurrent disease.

Most quality of life tools in head and neck cancer reflect the entire patient pathway including radiotherapy; none reflect solely on patient's surgical experience. So in order to improve services we have commenced a working group to design a specific patient questionnaire on experiences after head and neck surgery and we hope this will help us improve services further.

"The cranial nerve centre is currently in its infancy but could revolutionise patient care in head and neck surgery worldwide."

Services we provide

Maxillofacial service - orthognathic treatment

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

Patient satisfaction with orthognathic treatment

	2013/14	2014/15	2015/16	2016/17	2017/18
How do you rate the orthodontic service and care?	83% excellent 17% good	88% excellent 12% good	95% excellent 5% good	92% excellent 8% good	92% excellent 8% good
How do you rate the quality of surgical care?		91% excellent 8% good 1% average	94% excellent 6% good	90% excellent 10% good	89% excellent 11% good
How satisfied are you with your facial appearance?	71% very satisfied 28% satisfied 1% neither satisfied or dissatisfied	68% very satisfied 29% satisfied 3% neither satisfied or dissatisfied	84% very satisfied 16% satisfied	71% very satisfied 29% satisfied	70% very satisfied 29% satisfied 1% very dissatisfied
How satisfied are you with your dental appearance?	72% very satisfied 27% satisfied 1% neither satisfied or dissatisfied	80% very satisfied 20% satisfied	84% very satisfied 16% satisfied	76% very satisfied 22% satisfied Very dissatisfied 2%*	80% very satisfied 18% satisfied 1% very dissatisfied

*The Trust has investigated this patient's data, which is very positive overall about the surgery which was performed at QVH. It is possible that the form was filled in incorrectly, and further feedback will be sought when the patient is reviewed at two years.

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

Orthodontics

QVH provides a specialist consultant led orthodontic service. Our four orthodontic consultants also provide specialist care for patients requiring orthodontics and jaw surgery; cleft lip and palate care; hypodontia (care for patients with multiple missing teeth); buried/impacted teeth and sleep apnoea (care for patients with sleep disordered breathing).

We accept referrals from local doctors and dentists, specialist orthodontists, sleep physicians, consultants in other hospitals and those connected with cleft lip and palate care.

The unit is also a major teaching centre with several specialist trainees and therapists; our trainees are linked to Guy's Hospital, a major teaching institute in London.

We work closely with surgical and dental consultant colleagues in other areas of practice to produce a team approach to delivering multidisciplinary care for patients with both complex and routine problems. We see about 1,500 new patients a year and manage around 17,500 patient attendances. Our aim is to provide a service delivering clinical excellence with high levels of patient satisfaction.

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

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

The PAR provides an objective measure of the improvement gained by orthodontic treatment. The higher the pre-treatment PAR score, the poorer the bite or occlusion; a fall in the PAR score reflects improvement in the patient's condition. Improvement can be classified into: 'greatly improved', 'improved' and 'worse/no different'. On both scales, QVH scores well.

In 2017, 98.6% of our patients were assessed as 'greatly improved' or 'improved'. This is shown in the table below.

Percentage of patients achieving an outcome in the improved or greatly improved category National Gold Standard: 70% in this category.

	2013	2014	2015	2016	2017
PAR score	95%	95%	98%	98%	98.6%

*Data is produced one year in arrears

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

In addition to PAR ratings, patients are asked about their satisfaction with treatment. Every patient who completes orthodontic treatment is asked to complete a confidential questionnaire. In 2017, 285 patients completed the satisfaction questionnaire. The significant majority (86%) were completely satisfied with the result of their treatment and the remaining 12% were fairly satisfied, and 1% a little satisfied. No patient was disappointed.

Furthermore, 99% were happy that their teeth were as straight as they would have hoped; 70% reported improved self-confidence; 60% reported an improved ability to keep teeth clean; 62% reported improved ability to chew; and 21% reported improved speech.

A total of 98% of patients felt that they were given sufficient information regarding their proposed treatment; 99% of patients said that they were glad they undertook their course of treatment; and 92% would recommend a similar course of treatment to a friend.

Mandibular advancement splint

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

Over the years, QVH's referrals have increased as patients continue to experience a positive outcome to their apnoeic symptoms. Patients are screened before their referral to the orthodontics department to assess their suitability, with reported success rates from previous audits of 82-85%.

This year saw the fourth cycle of the patient satisfaction audit. The audit also aims to identify those patients who are most likely to benefit from a mandibular advancement splint by investigating the clinical parameters that indicate the highest probability of a positive response. Our 'on the day digital kiosk' allows patients to capture their treatment feedback as they leave the unit and this has received positive comments. Overall, the orthodontic sleep service found an 86% resolution in apnoeic symptoms, which is in line with the published literature, as well as patients continuing to have improved wellbeing.

Maxillofacial prosthetics service

QVH is Europe's largest maxillofacial prosthetic rehabilitation centre, offering all aspects of care, including facial and body prosthetics; cranial implants; indwelling ocular prosthetics; rehabilitation after head and neck cancer or plastic surgery; and surgical guides for jaw alignment surgery. The team were mentioned as outstanding in the last CQC report. The service at QVH is one of only five accredited maxillofacial prosthetics training institutions, and as such has government funded training posts, under the modernising scientific careers: scientist training programme.

We offer patients the full range of maxillofacial device treatments and are at the forefront of several evidenced based research projects. QVH is the lead site for the national portfolio artificial eye study. This study is collecting nationwide data on artificial eye patients via a questionnaire covering patient's cleaning regimes, the presence of any deposit/discharge for ocular prostheses, overall experience of ocular rehabilitation treatment and quality of life after eye loss. This data will enable investigation into adapting to monocular vision and add to the current evidence base available in the published literature. The goal is to produce a simple and readily available information leaflet available in clinics and online. This study hopes to improve patients' artificial eye tolerance and reduce deposit build up, reduce symptoms of discharge, ultimately improving the patient experience. The study co-ordinator has just won the Rising Star Award from the Kent Surrey and Sussex Clinical Research Network for showing dedication and motivation to this QVH-led study. A large number of sites (currently 36) across the country have now signed up. Such evidence based research will inform and prepare patients experiencing eye loss in the future and be useful in NHS clinics, GP surgeries and affiliated organisations.

The team supports and networks with other maxillofacial prosthetics departments through joint collaboration, and offering free training days for MSc level trainees.

The maxillofacial prosthetics department have been supported by QVH Charity to purchase a 3D scanner and printer for rapid prototyping and for the design/engineering service to be available in-house.

Services we provide

Sleep disorder centre

The sleep disorder centre is now 25 years old and well established. It employs five consultants from parent specialties of chest medicine, neurology and anaesthetics, supported by 15 technicians and 19 administrative staff. Over 3,000 new referrals per year are received from all over the south of England. It is one of the six largest centres in the UK, and admits up to 42 patients for inpatient studies per week, with 15 outpatient clinics per week, and day case admissions for therapy each weekday.

The facilities are self-contained and include six fully air-conditioned inpatient study bedrooms, four outpatient clinic rooms, a pleasant reception and waiting area, and a technician control room.

The centre receives referrals for all sleep disorders in adults, including:

- insomnia
- sleep disordered breathing
- disorders of central hypersomnolence
- parasomnias
- circadian rhythm disorders
- movement disorders.

The department is one of the only centres in the UK where all treatments for sleep disordered breathing are available, including continuous positive airway pressure (CPAP), non-invasive ventilation (NIV), adaptive servo ventilation (ASV), mandibular advancement splints provided the orthodontic department, and maxillofacial surgery for bimax osteotomy.

Pharmacological treatments are frequently undertaken and a shared care policy is being developed with primary care to provide specialist support in the community.

Referrals have increased over the last two years, from 2,200 to over 3,000 per annum. The greater complexity of the workload, especially in chest medicine, COPD and obesity hypoventilation syndrome, means that more specialised equipment is needed, and the department now has a blood gas analyser, glucose refractometer and ECG machine. Blood for haematology and chemical pathology is taken and sent directly from the centre without need to refer on to general outpatients.

This greater complexity also requires highly trained staff, and the senior technicians are all registered polysomnographic technicians or equivalent, whilst others are in training for the examination, or assume a support role.

In 2017 the team gave more than ten talks and presentations to national and international meetings, GPs, trainees and patients groups. The clinical lead is an elected member of the Committee of the British Sleep Society and is actively engaged in developing an accreditation process for sleep centres in the UK, in conjunction with the European Sleep Research Society.

The department is active in research, and presented four original projects at the biennial international meeting of the British Sleep Society in 2017, one reaching the top five in the opinion of the judging panel.

The service is looking to undertake further research into the benefits of brain stimulants in patients with subcortical arousal in sleep.

Radiology department

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

The radiology department provides general radiography, fluoroscopy, non-obstetric ultrasound and cone beam computed tomography services (CBCT) on site. We also offer on-site services for diagnostic and therapeutic sialography and MSK ultrasound.

MRI is currently delivered on the QVH site three days a week in partnership with a third party provider and we are planning to extend the MRI services provided at QVH in 2018.

The current CBCT is being replaced in April 2018 by a new machine that is capable of scanning large and small field of view examinations. This means patients will be seen locally rather than needing to travel to London for small field of view examinations.

QVH patients referred for CT scans are offered appointments in neighbouring NHS trusts or private providers. From August 2018 QVH will be offering an on-site CT service managed by the QVH radiology team.

Our radiology services are provided for inpatient, outpatient and minor injuries unit patients at QVH and we provide direct access for our GP community.

The radiology department is an Any Qualified Provider (AQP) for ultrasound services for Crawley and Horsham and Mid Sussex CCGs. As part of this contract we report monthly performance figures demonstrating that we constantly deliver the service within the performance indicators laid out by the CCGs.

In November 2015, we partnered with Sussex Community NHS Foundation Trust to provide a general radiography reporting service for Crowborough and Uckfield. Radiology management and clinical support, including staffing, for the diagnostic services in the High Weald, Lewes and Havens area is delivered by QVH.

Although there is no agreed national benchmark for report turnaround times within radiology, QVH expects to maintain an internal target that at least 80% of all CT, MRI, ultrasound and general radiography will be reported within 48 hours from image acquisition. We are routinely exceeding this target and reporting figures of 90-95%.

Monthly returns identify any waiting time breaches, with patients waiting more than six weeks where the clock has not been stopped for approved reasons. Over the last two years QVH has seen an increase in patients waiting over six weeks, mainly due to increased referrals across all modalities, which is stretching our capacity and the reliance on out-sourcing for all CT and paediatric MRI examinations. These patient waits continue to be monitored and the expectation is that with on-site CT available in late 2018 we will have better control of our ability to meet this target.

The radiology department is in the process of applying for the Imaging Services Accreditation Scheme (ISAS). ISAS supports radiology departments to manage the quality of their services and make continuous improvements. This accreditation process will help ensure our patients and referrers consistently receive high quality of service. Our ISAS submission and completion is due in late September 2018.

	Measurement	2016/17	2017/18
Report turnaround time	Percentage of CT, MRI, ultrasound and plain film reported within 48 hours	Routinely over 90%	Average over 90%
Diagnostic waiting times	Waiting times for routine ultrasound access	2-3 weeks	3-4 weeks
Diagnostic waiting time performance	Percentage of patients referred for CT, MRI or non-obstetric ultrasound seen within six weeks of referral	Over 90%	Over 90%
AQP non-obstetric ultrasound	95% of all urgent referrals will be scanned within 5 working days	Over 95%	Over 95%
	95% of all routine referrals will be scanned within 15 working days	100%	Average 99-100%
DNA rates for radiology (patients who do not attend)	Percentage of patients that do not attend their appointment across radiology	5%	3%
WHO checklist audit for ultrasound and fluoroscopy	Percentage of patients that have completed checklist forms scanned into the radiology information system.	95%	96%

"Our radiology services are provided for inpatient, outpatient and minor injury unit patients at QVH and we provide direct access for our GP community."

Services we provide

Therapies

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

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

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

> "We aim to provide a safe, equitable and patient-focused service that delivers value for money and the highest standards of therapy with effective treatment and advice."

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

- **Patient specific functional score (PSFS)** - an outcome measure which assists in identifying activities impaired by illness or injury. Our target, and an indication of clinical significance, is for a change of 3 points or more.
- **QuickDASH** - measures physical function and symptoms in people with musculoskeletal disorders of the upper limb. Until 2016/17 a change exceeding 7 points was the most accurate change score for discriminating between improved and stable patients. More recently this has moved to a change exceeding 18.
- **TOM** - The Therapy Outcome Measure (TOM) allows professionals from many disciplines working in health, social care and education to describe the relative abilities and difficulties of a patient/client in the four domains of impairment, activity, participation and wellbeing in order to monitor changes over time.
- **POSAS** – The Patient and Observer Scar Assessment Scale (POSAS) is a questionnaire that was developed to assess scar quality. It consists of two separate six-item scales (observer scale and patient scale), both of which are scored on a ten point rating scale. An improvement of 5% is deemed clinically significant.
- **FGS** – The Sunnybrook facial grading system grades patients based on their resting symmetry, symmetry of voluntary movement and synkinesis (involuntary muscular movements accompanying voluntary muscular movements). A composite score is given with a total possible score of 100.
- **New patient to follow-up ratio (NP:FU)** - depending on the service there is often a target ratio which is generally less than six follow up appointments to every initial appointment on average. Services such as musculoskeletal physiotherapy would be expected to meet a lower ratio of 1:5, whereas services treating long term, progressive conditions will demonstrate higher ratios. Low ratios are not at the expense of clinical outcomes, but instead demonstrate effective and efficient treatment.
- **Shared Decision Making** - the government has made a strong commitment to ensuring that the health service promotes the involvement of patients in decisions about their care and treatment. Our target is to ensure that over 80% of our patients referred with knee and/or hip osteoarthritis receive shared decision making information packs (patient decision aids).
- The Burns Standards state that **FAB (Functional Assessment of Burns) assessments** must be carried out within 24 hours of admission.

We also use service specific surveys to monitor patient satisfaction.

	Target	2013/14	2014/15	2015/16	2016/17	2017/18
Effective (clinical outcomes)						
PSFS change (MSK)	≥ 3	3.99	4.17	4.2	4.24	4.00
Quick DASH change- Conservative (Hands)	>18	N/A	19.29	15.16	20.4	21.07*
Quick DASH change – Surgery elective (Hands)	>18	N/A	22.48	19.18	18.33	18.46*
Quick DASH change - Surgery trauma (Hands)	>18	N/A	38.97	31.54	33.5	37.91*
POSAS (Burns)	>5%	N/A	N/A	N/A	7.13%	8.45%
FGS (Facial palsy)	≥60%	N/A	N/A	N/A	69%	Data unavailable
Effective (NP:FU)						
NP:FU ratio (Physio)	≤ 5	4.2	4.6	4.1	3.47	3.44
NP:FU ratio (occupational therapy)	≤ 5	3.9	4.9	4.5	3.71	2.72
NP:FU ratio (speech and language therapy)	≤ 5	4	4.6	3.2	3.09	2.94
NP:FU ratio (dietetics)	≤ 5	3	3.7	4.2	4.08	4.34
Average new to follow up ratio	≤ 5	3.8	4.45	4	3.58	3.09
Discharge reports sent within 7 working days (MSK)	>90%	N/A	N/A	N/A	95%	96%
Shared decision making information issued to patients with knee and hip osteoarthritis	>80%	N/A	N/A	N/A	90%	88%**
Patient experience						
Patient satisfaction - MSK (%)	>90%	98%	98%	100%	99%	98%
Patient Satisfaction – Rehab (%)	>90%	N/A	N/A	N/A	100%	95%
Patient Satisfaction – Facial Palsy (%)	>90%	N/A	N/A	N/A	95%	100%
Patient Satisfaction – Hands (%)	>90%	N/A	N/A	N/A	N/A	100%
Burns standard - FAB review within 72hrs (%)	>90%	N/A	N/A	100%	100%	94.4%

* based on data from April 17 to December 18

**based on data from April 17 to February 18

Statement of directors' responsibilities for 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.

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

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2017 to 24 May 2018
  - papers relating to quality reported to the board over the period April 2017 to 24 May 2018
  - feedback from commissioners dated 17/05/2018
  - feedback from governors dated 15/05/2018
  - feedback from local Healthwatch organisations. Healthwatch West Sussex chose not to comment on the quality report but provide feedback to the Trust through a variety of channels
  - West Sussex Health and Adult Social Care Overview and Scrutiny Committee chose not to comment on this quality report as they had not been involved in any significant work with QVH in 2017/18
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 07/09/2017
  - the latest national patient survey 03/05/2018
  - the latest national staff survey published March 2018
  - the head of internal audit's annual opinion of the trust's control environment dated May 2018
  - CQC inspection report dated 26/04/2016
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review, and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board,

Chair
24 May 2018

Chief Executive
24 May 2018

Statement from third parties

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

Crawley and Horsham and Mid-Sussex CCG welcome the opportunity to comment on and contribute to the draft quality account 2017/18 and clinical quality of services provided by Queen Victoria Hospital NHS Foundation Trust.

We support the Trust strategic outlook which seeks to address and improve the health of the local population and is aligned to deliver the NHS national priorities.

Over the past year, together with other stakeholders, Crawley and Horsham and Mid-Sussex CCG have worked closely with the executive team to support the delivery of quality and patient safety initiatives which aim to improve patients experience and clinical outcomes. The CCG would like to note the Trust continues to focus on patient safety embedding a culture of transparency in encouraging staff to report safety incidences.

The Quality accounts reflect the Trusts on-going commitment to quality improvement addressing key issues in a focused and innovative way. The account summarises the achievements against the Trust quality priorities.

Furthermore the Trust has identified three key areas of focus where improvements are a priority for 2018/19, of which the CCG is in agreement, and the CCG quality team welcomes the opportunity to work with the Trust and support these improvements, as outlined within the report especially building on patient safety in theatres.

The CCG would like to thank the Trust for the opportunity to contribute towards the Quality Account and looks forward to developing its relationships with the Trust in 2018/19.

17 May 2018

Statement from QVH Council of Governors

The QVH Council of Governors are pleased to comment on the quality account. In our view the quality account is consistent with the services and activities of the Trust over this last year. In terms of the priorities for 2017/18 the Council of Governors understood the necessity of increasing theatre productivity so that we improve the experience for patients including reducing waiting times as well as ensuring the Trust is making best use of NHS funds. We welcome the fact that the priority is now being reviewed over a two year programme and thus will remain a priority for 2018/19. We also welcome the increased awareness of mouth care issues and are very pleased that the focus on the patient experience within the Trust is seeing improvements to children's and other waiting areas.

For 2018/19 we understand the need to put patient safety first in terms of a priority which we want to measure and support the success criteria of having no Never Events in 2018/19. We note the Never Events which occurred in 2017/18 and also the steps that are being introduced both to ensure non-recurrence and more widely to ensure they are prevented through training, audits and other compliance checks. Having heard a number of stories from patients about their largely positive experiences at being dealt with by the Trust we are pleased to see further focus on ensuring the Trust seeks to improve further the communication between clinicians and patients.

The Council of Governors commends the remainder of the report which demonstrates the Trust's commitment to the highest standards of patient safety, patient experience and improving our services and activities. We also welcome the commitment being shown to our staff in terms of improving the environment in which they work as well as focusing on their training and development. The Council of Governors is not complacent in the face of the challenges faced by the Trust but is extremely grateful for all the hard and outstanding work undertaken by all staff members of the Trust over the last 12 months, in part reflected within the content of this quality statement.

15 May 2018

West Sussex Health and Adult Social Care Overview and Scrutiny Committee

West Sussex HASC Overview and Scrutiny Committee chose not to comment on this quality account as they had not been involved in any significant work with QVH in 2017/18.

Healthwatch West Sussex

Healthwatch West Sussex chose not to comment on the quality account. Healthwatch West Sussex remains committed to providing feedback to the Trust through a variety of channels to improve the quality of care, experience and safety of its patients.

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

We have been engaged by the Council of Governors of Queen Victoria Hospital NHS Foundation Trust ('the Trust') to perform an independent assurance engagement in respect of the Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following two national priority indicators (the indicators):

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

We refer to these national priority indicators collectively as the 'indicators'.

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 NHS Improvement.

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2017/18* ('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 *Detailed Requirements for external assurance for quality reports for foundation trusts 2017/18.*

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 and papers for the period April 2017 to May 2018;
- papers relating to quality reported to the Board over the period April 2017 to May 2018;
- feedback from commissioners, dated 17 May 2018;
- feedback from governors, dated 15 May 2018;
- feedback from local Healthwatch organisations, requested 25 April 2018;
- feedback from West Sussex County Council Health and Adult Social Care Select Committee, requested 24 April 2018;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national patient survey, dated 2017;
- the latest national staff survey, dated 2017;
- Care Quality Commission Inspection, report dated 26 April 2016;

- the 2017/18 Head of Internal Audit's annual opinion over the Trust's control environment, dated 23 May 2018; and
- any other information included in our review.

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 the Trust as a body, to assist the Council of Governors in reporting the Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate it has discharged its 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 Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

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

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

Limitations

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* and supporting guidance.

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

Basis for adverse conclusion on the 18 Week RTT indicator and the 62 day cancer waits indicator

As set out in the Statement on Quality from the Chief Executive of the Foundation Trust on page 75 of the Trust's Quality Report, the Trust currently has concerns over the accuracy of data relating to the 18 week RTT and 62 day cancer waits indicators.

With regards to the 18 week RTT indicator, we identified that there is a weakness in the design of the controls, as the data from the satellite site at Medway Hospital is not included as a matter of policy due to unavailability and incompatibility of data provided for activity at this site. Procedures specified for reporting purposes were followed by the clinical team, but our testing identified that the indicator is not complete. In addition, our sample testing of this indicator identified 10 errors, where there were discrepancies between clock start and stop times recorded on the Patient Administration System ("PAS") and patient referral letters, and where incomplete pathways reported in PAS did not agree to underlying patient records.

With regards to the 62 day cancer waits indicator, we identified 15 errors in our sample testing of the data comprising the indicator. These errors related to discrepancies between data recorded in PAS and underlying patient records, including a lack of available patient referral evidence from other referring bodies.

As a result of these issues, we have concluded that the 18 week RTT indicator and the 62 day cancer waits indicators for the year ended 31 March 2018 have not been 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.

Conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for adverse conclusion on the 18 week RTT indicator and the 62 day cancer waits indicator' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- 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 Guidance; and

KPMG LLP

KPMG LLP

Chartered Accountants

15 Canada Square

London

E14 5GL

25 May 2018

5 Auditor's report and certificate

"Participation in research helps our clinical staff to stay abreast of the latest treatment possibilities and enables us to deliver improved patient outcomes"

KPMG

Independent auditor's report

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

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of Queen Victoria Hospital NHS Foundation Trust ("the Trust") for the year ended 31 March 2018 which comprise the statement of comprehensive income, the statement of financial position, the statement of cash flows, the statement of changes in taxpayers' equity, and the related notes, including the accounting policies in note 1.

In our opinion:

— the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended; and

— the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2017/18 and the Department of Health Group Accounting Manual 2017/18.

Basis for opinion

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

Overview		
Materiality: financial statements as a whole	£1.3m (2016/17:£1.3m) 2% (2016/17: 2%) of income from operations	
Risks of material misstatement		**vs 2016/17**
Recurring risks	Valuation of land and buildings	◀▶
	Recognition of NHS and non-NHS revenue	◀▶

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

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

	The risk	Our response
Plant, Property and Equipment (£40.3m; 2016/17: £37.2m) *Refer to page 44 (Audit Committee Report), page 162 (accounting policy) and page 177 (financial disclosures)*	**Subjective valuation** Land and buildings are required to be held at fair value. The Trust's main land and buildings relate to the site at Queen Victoria Hospital, East Grinstead. Land and buildings are required to be maintained at up to date estimates of year-end market value in existing use (EUV) for non-specialised property assets in operational use, and, for specialised assets where no market value is readily ascertainable, the depreciated replacement cost of a modern equivalent asset that has the same service potential as the existing property (MEAV). There is significant judgment involved in determining the appropriate basis (EUV or MEAV) for each asset according to the degree of specialisation, as well as over the assumptions made in arriving at the valuation and the condition of the asset. In particular, the MEAV basis requires an assumption as to whether the replacement asset would be situated on the existing site or, if more appropriate, on an alternative site, with a potentially significant effect on the valuation. The Trust values land and non-specialised buildings using the MEAV valuation methodology, and values specialised assets using the depreciation replacement cost methodology. The Trust undertakes the valuation on an alternative site valuation basis to reflect that if a modern equivalent hospital were rebuilt, it would be rebuilt in a 2 – 3 storey design, in a more central location within its surrounding area. Valuations are inherently judgmental, therefore our work focused on whether the valuer's methodology, assumptions and underlying data, are appropriate and correctly applied. The last full valuation was as at 31 March 2017.	Our procedures included: — **Assess valuer's credentials:** We assessed the competence, capability, objectivity and independence of the Trust's external valuer and consider the terms of engagement of, and the instructions issued to, the valuer for consistency with the requirements of the Department of Health's Group Accounting Manual 2017/18; — **Data comparisons:** We reconciled the information supplied to the external valuer to the Fixed Asset Register; — **Tests of details:** We critically assessed the appropriateness of the valuation bases and assumptions applied to a sample of material assets subject to the revaluation exercise by reference to property records held by the Trust on the condition of the assets, the basis of ownership and the basis of their use; — **Methodology implementation:** We considered how management and the Trust's valuer had assessed the need for any impairment across its asset base either due to loss of value or reduction in future benefits that would be achieved; and — **Assessing transparency:** We considered the adequacy of the disclosures about the key judgments and degree of estimation involved in arriving at the valuation and the related sensitivities with reference to the Group Accounting Manual 2017/18.

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

	The risk	Our response
Recognition of NHS and non-NHS revenue (£69.9m; 2016/17: £68.5m) *Refer to page 44 (Audit Committee Report), page 162 (accounting policy) and page 171 (financial disclosures)*	**2017/18 income** In 2017/18, the Trust reported total income of £69.9m (2016/17, £68.5m). Of this, £62.0m (2016/17: £60.4m) relates to contracts with NHS commissioners. This represents 89% of total income (2016/17: 88%). The remaining £7.9m (2016/17: £8.1m) was from contracts with other NHS bodies, local authorities and other non-NHS organisations. The Trust participates in the Agreement of Balances (AoB) exercise which is mandated by the Department of Health (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. Mismatches in income and expenditure, and receivables and payables are recognised by the Trust and its counterparties to be resolved. Where mismatches cannot be resolved they can be reclassified as formal disputes. **Accounting treatment** The Trust is eligible to receive Sustainability and Transformation Plan funding (STF) based on meeting the control total set by NHS Improvement. The final income from STF may be notified late in the financial year.	Our procedures included: — **Tests of details:** We undertook the following tests of details: • For a sample of the Trust's commissioners we agreed that signed contracts were in place; • We agreed through testing a sample of invoices that they had been issued in line with the contracts signed with a sample of the Trust's commissioners; • We tested a sample of contract variations between the Trust and commissioners at the end of the year of actual activity; • We assessed the outcome of the AoB exercise with other NHS bodies. Where there were mismatches over £250,000 we obtained evidence to support the Trust's reported income figure; • We tested a sample of non-NHS income items to year-end bank statements and third party notifications to support the work we have undertaken on completeness of income balances recorded in the financial statements and confirming that income has been recorded in the correct accounting period; and — **Accounting analysis and transparency:** Assessing the Trust's reporting and accounting for STF income received from the Department of Health.

3. Our application of materiality

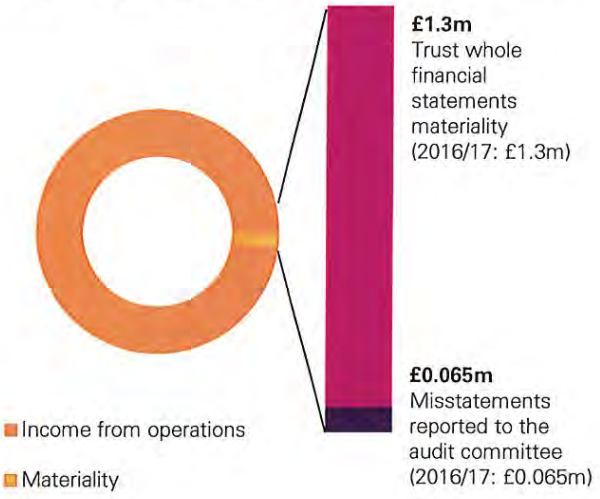
Materiality for the Trust financial statements as a whole was set at £1.3 million (2016/17: £1.3 million), determined with reference to a benchmark of budgeted income from operations (of which it represents approximately 2%). We consider income from operations to be more stable than a surplus or deficit related benchmark.

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.065 million (2016/17:£0.065 million), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Our audit of the Trust was undertaken to the materiality level specified above and was performed at the Trust's site at Queen Victoria Hospital in East Grinstead.

Income from operations
£69.9m (2016/17: £68.5m)

Materiality
£1.3m (2016/17: £1.3m)



£1.3m
Trust whole financial statements materiality (2016/17: £1.3m)

£0.065m
Misstatements reported to the audit committee (2016/17: £0.065m)

4. We have nothing to report on going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

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

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

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

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

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

Corporate governance disclosures

We are required to report to you if:

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

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

— the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 65, the Accounting Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

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

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

— any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

We have nothing to report in respect of our work on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

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

We have nothing to report in this respect.

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

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

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

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

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

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

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

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

Our risk assessment exercise did not identify any significant risks.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

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

CERTIFICATE OF COMPLETION OF THE AUDIT

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

Neil Hewitson

for and on behalf of KPMG LLP (Statutory Auditor)

Chartered Accountants

15 Canada Square

London

E14 5GL

25 May 2018

6 Annual accounts 2017/18

"We aim to provide a safe, equitable and patient-focused service that delivers value for money and the highest standards of therapy with effective treatment and advice"

6.1 Annual accounts 2017/18

Foreword to the accounts

These accounts for the year ended 31 March 2018 have been prepared by Queen Victoria Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Steve Jenkin
Chief Executive
24 May 2018

Statement of comprehensive income

STATEMENT OF COMPREHENSIVE INCOME FOR THE PERIOD ENDED 31 MARCH 2018			
	Notes	**2017/18 £000**	2016/17 £000
Operating income from patient care activities	3	**63,075**	61,602
Other operating income	4	**6,853**	6,930
Operating expenses	5-7	**(65,495)**	(65,291)
Operating surplus		**4,433**	3,241
Finance costs			
Finance income	10	**19**	15
Finance expense – unwinding of discount on provisions	19	**(1)**	(1)
Finance expense – other	20	**(195)**	(217)
PDC dividends payable		**(1,255)**	(1,125)
Net finance costs		**(1,432)**	(1,328)
RETAINED SURPLUS/(DEFICIT) FOR THE YEAR		**3,001**	1,913
Other comprehensive income (See Statement of Changes in Taxpayers' Equity on page 130)			
Revaluation gains on property, plant and equipment	12	**2,680**	2,162
Impairment through revaluation reserve	12	**(26)**	(766)
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**5,655**	3,309

The notes on pages 132 to 154 form part of these accounts.

Statement of financial position

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2018			
	Notes	**31 March 2018 £000**	31 March 2017 £000
NON-CURRENT ASSETS			
Intangible assets	11	**715**	410
Property, plant and equipment	12	**46,873**	43,869
Total non-current assets		**47,589**	44,279
CURRENT ASSETS			
Inventories	14	**1,178**	429
Trade and other receivables	15	**9,169**	7,383
Cash and cash equivalents	16	**8,914**	7,784
Total current assets		**19,261**	15,596
CURRENT LIABILITIES			
Trade and other payables	17	**(8,902)**	(6,787)
Borrowings	21.1	**(778)**	(778)
Provisions	19	**(40)**	(43)
Other liabilities	18	**(166)**	(164)
Total current liabilities		**(9,885)**	(7,772)
NON-CURRENT LIABILITIES			
Provisions	19	**(625)**	(641)
Long term borrowings	21.1	**(5,823)**	(6,600)
Total non-current liabilities		**(6,448)**	(7,241)
TOTAL ASSETS EMPLOYED		**50,517**	44,862
TAXPAYERS' EQUITY (See Statement of Changes in Taxpayers' Equity on page 130)			
Public dividend capital		**12,237**	12,237
Revaluation reserve		**12,182**	10,011
Income and expenditure reserve		**26,098**	22,614
TOTAL TAXPAYERS' EQUITY		**50,517**	44,862

The accounts on pages 128 to 154 were approved by the Board on 21 May 2018 and are signed on the Board's behalf by:

Steve Jenkin

Chief Executive

24 May 2018

The notes on pages 132 to 154 form part of these accounts.

Statement of changes in taxpayers' equity

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY				
2017/18	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	**Total £000**
Taxpayers' equity at 1 April 2017	**12,237**	**10,011**	**22,614**	**44,862**
Retained Surplus for the year	-	-	3,001	**3,001**
Revaluation of property, plant and equipment	-	2,680	-	**2,680**
Impairments	-	(26)	-	**(26)**
Other reserve movements	-	(483)	483	**-**
Taxpayers' equity at 31 March 2018	**12,237**	**12,182**	**26,098**	**50,517**

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY				
2016/17	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	**Total £000**
Taxpayers' equity at 1 April 2016	12,237	9,143	20,173	41,553
Retained Surplus for the year	-	-	1,913	1,913
Revaluation of property, plant and equipment	-	2,162	-	2,162
Impairments	-	(766)	-	(766)
Other reserve movements	-	(528)	528	-
Taxpayers' equity at 31 March 2017	12,237	10,011	22,614	44,862

The notes on pages 132 to 154 form part of these accounts.

Statement of cash flows

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2018			
	Notes	**2017/18 £000**	2016/17 £000
Operating surplus		**4,433**	3,241
Non-cash income and expense			
Depreciation and amortisation	5	**2,836**	2,707
Impairments and reversals	5	**(182)**	1,072
Non-cash donations recognised in income	4	**(148)**	(18)
(Increase)/decrease in inventories	14	**(749)**	10
(Increase)/decrease in trade receivables	15	**(1,785)**	(1,589)
Increase/(decrease) in trade and other payables	17	**2,346**	491
Increase/(decrease) in provisions	19	**(19)**	(31)
Increase/(decrease) in other liabilities	18	**2**	(850)
Net cash inflow from operations		**6,733**	5,033
Cash flows from investing activities			
Interest received	10	**19**	15
Payments to acquire intangible assets	11	**(512)**	(5)
Payments to acquire property, plant and equipment	12	**(2,916)**	(2,487)
Net cash used in investing activities		**(3,409)**	(2,477)
Cash flows from financing activities			
Loans repaid to the Independent Trust Financing Facility	21.1	**(778)**	(778)
Interest paid	20	**(202)**	(224)
PDC dividends paid		**(1,214)**	(1,055)
Net cash generated from/(used in) financing activities		**(2,194)**	(2,057)
Increase in cash		**1,130**	499
Cash and cash equivalents at 1 April	16	**7,784**	7,285
Cash and cash equivalents at 31 March	16	**8,914**	7,784

The notes on pages 132 to 154 form part of these accounts.

Notes to the financial statements

1 Accounting policies

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to 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.

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

1.3 Expenditure on other goods and services

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

1.4 Property, Plant and Equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and

- the cost of the item is at least £5,000; or
- groups of items collectively have a cost of at least £5,000, individually have a cost of more than £250, are functionally interdependent, have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

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

Measurement

Valuation

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

To this end, valuations of land, buildings and fixtures are carried out by professionally qualified external valuers (Gerald Eve LLP - RICS Registered Valuers, a regulated firm of Chartered Surveyors) in accordance with the requirements of the Valuation-Global Standards 2017, the International Valuation Standards and IFRS as adapted by FReM. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the balance sheet date. Revaluations are never less than triennial. The latest valuations were undertaken in 2018 as at the prospective valuation date of 31 March 2018 and were accounted for in the 2017/18 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.

Subsequent expenditure

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

Depreciation

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

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

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

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust.

Revaluation and impairment

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

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

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

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

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

Land and buildings were revalued as at 31 March 2018.

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

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

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

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

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

Donated assets

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

1.5 Intangible assets

Recognition

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

Internally generated intangible assets

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

Expenditure on research is not capitalised.

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

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

and sell or use the asset; and

- the Trust can measure reliably the expenses attributable to the asset during development.

Software

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

Measurement

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

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

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

Amortisation

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

1.6 Inventories

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

1.7 Cash and cash equivalents

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

1.8 Trade receivables

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

1.9 Trade payables

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

1.10 Financial assets and financial liabilities

Recognition

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

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

De-recognition

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

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

Classification and measurement

Financial assets are categorised as 'Loans and Receivables'.

Financial liabilities are classified as 'Financial Liabilities'.

Loans and receivables

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

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

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

Financial Liabilities

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

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

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flow 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. 10 years) and there is no provision for the transfer of title, the lease is considered to be an operating lease.

The Trust as lessor

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

1.12 Provisions

The 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

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

Other NHS Resolution schemes

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

1.13 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 non-current 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 2018.

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 as income or expense in the period in which they arise.

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

1.18 IASB standard and IFRIC interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

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

i) IFRS 9 - Financial Instruments.
Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

ii) IFRS 14 - Regulatory Deferral Accounts
Not yet adopted by the EU. Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DH group bodies.

iii) IFRS 15 - Revenue from Contracts with Customers
Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

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

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 £40,258,000 (2016/17 £37,170,000) - 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 2017/18 financial year end, the estimated value of partially completed spells is £43,000 (2016/17 £61,000).

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

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

1.20 Operating segments

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

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

1.21 Consolidation of accounts

The Trust is the corporate trustee to the Queen Victoria Hospital NHS Trust Charitable Fund and as such has the power to govern its financial and operating policies so as to obtain benefits from its activities for itself, its patients or its staff. In 2013/14 the Trust was expecting the charity to grow substantially in the succeeding years and therefore determined it to be a material subsidiary. Consolidated accounts were prepared from 2013/14 onwards. In the event, the size of the charity has declined over the years, causing the Trust to re-assess its policy in regard to materiality and consolidation. It was decided for the 2016/17 annual accounts that it was no longer appropriate to consolidate the accounts of the Trust and the Charity, and the accounts therefore relate solely to the Trust.

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

2. Operating segments

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

	2017/18 £000	2016/17 £000
Income	**69,928**	68,532
Segment surplus (deficit)	**3,001**	1,913
Segment net assets	**50,517**	44,862

3. Income from patient care activities by nature

	2017/18 £000	2016/17 £000
Eyes	**6,456**	5,815
Oral	**13,192**	13,202
Plastics	**29,768**	30,517
Sleep	**4,597**	4,235
Other	**9,062**	7,833
	63,075	61,602

Income from patient care activities by source

	2017/18 £000	2016/17 £000
Clinical commissioning groups and NHS England	**62,003**	60,378
Other NHS bodies	**127**	168
Private patients	**98**	92
Injury costs recovery	**220**	334
Other	**628**	630
	63,075	61,602

Notes:

'Injury costs recovery' is income received through the NHS injury scheme from insurance companies in relation to the treatment of patients who have been involved in road traffic accidents. It is subject to a provision for impairment of receivables of 22.84% to reflect expected rates of collection.

Commissioner requested services

Within the 2017/18 financial statements management has taken the view that commissioner requested services are those which are provided for the healthcare of NHS patients. There is ongoing discussion between management and commissioners on the formal agreement of the definition of commissioner requested services.

Of the total income reported above, £62,977,000, (2016/17 £61,510,000) was derived from the provision of commissioner requested services.

4. Other operating income

	2017/18 £000	2016/17 £000
Education and training	**1,579**	1,656
Charitable and other contributions or donations	**148**	18
Non-patient care services to other bodies	**1,915**	2,482
Sustainability and Transformation Fund	**2,122**	1,673
Other income	**1,090**	1,101
	6,853	6,930

5. Operating expenses

	2017/18 £000	2016/17 £000
Services from NHS foundation trusts	**110**	121
Services from NHS trusts	**-**	9
Purchase of healthcare from non-NHS bodies	**462**	201
Non-executive directors	**111**	105
Staff and executive directors	**44,030**	42,419
Research and development - staff costs	**253**	214
Consultancy	**117**	32
Drugs	**1,464**	1,351
Supplies and services - clinical (excluding drugs)	**10,419**	10,304
Supplies and services - general	**684**	760
Establishment	**676**	728
Transport	**564**	489
Premises	**2,445**	3,527
Provision for impairment of receivables	**(10)**	(285)
Depreciation	**2,630**	2,444
Amortisation	**207**	263
External audit – statutory audit	**51**	51
– audit-related assurance services	**8**	8
Internal audit services	**53**	49
Clinical negligence (payable to NHS Resolution)	**486**	365
Other	**917**	1,064
	65,677	64,219
Impairments of property, plant and equipment	**(182)**	1,072
	65,495	65,291

Note

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

External audit fees, exclusive of irrecoverable VAT, were £42,425 for statutory audit and £7,000 for audit related assurance services.

6. Operating leases

As lessee

Operating leases relate to buildings, medical equipment and vehicles.

A building is leased for a remaining period of one year.

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

Payments recognised as an expense	**2017/18 £000**	2016/17 £000
Minimum lease payments	**226**	303

Total future minimum lease payments	**2017/18 £000**	2016/17 £000
Payable:		
Not later than one year	**211**	212
Between one and five years	**-**	216
After 5 years	**-**	-
Total	**211**	428

7. Employee benefits and staff numbers

7.1 Employee benefits	**2017/18 £000**	2016/17 £000
Salaries and wages	**34,918**	33,454
Social security costs	**3,756**	3,406
Employer contributions to NHS Pension Scheme	**4,052**	3,942
Employer's contributions to Other Pension schemes	**4**	-
Agency/contract staff	**2,289**	2,947
Employee benefits expense	**45,020**	43,749
Recoveries in respect of seconded staff	**(410)**	(447)
Costs capitalised as part of assets	**(326)**	(669)
Total staff costs excluding capitalised costs	**44,284**	42,633

7.2 Average number of people employed	**2017/18 Trust Number**	2016/17 Trust Number
Medical and dental	**154**	146
Administration and estates	**286**	279
Healthcare assistants and other support staff	**128**	123
Nursing, midwifery and health visiting staff	**199**	198
Scientific, therapeutic and technical staff	**60**	61
Healthcare science staff	**99**	104
Total	**926**	911
Of which - Number of employees (WTE) engaged on capital projects	**2**	7

7.3 Directors' remuneration

This and other remuneration analysis is now contained within the Remuneration Report section of the Annual Report.

7.4 Staff exit packages for staff leaving in 2017/18

Staff exit packages are payable when the Trust terminates the employment of an employee before the normal retirement date or whenever an employee accepts compulsory redundancy in return for these benefits. During the year there were two cases in which contractual payments were made in lieu of notice.

Exit package cost band	**2017/18**		2016/17	
£000	**Number of exit packages**	**Total exit packages by cost band**	Number of exit packages	Total exit packages by cost band
Below 10 (payment in lieu of notice)	**2**	**2**	-	-
10-25 (payment in lieu of notice)	**-**	**-**	1	1
50-100 (compulsory redundancies)	**-**	**-**	1	1
Total	**2**	**2**	2	2

8 Retirements due to ill-health

During the year there were no early retirements due to ill health at a cost to the NHS pension scheme of £0 (2016/17, none at a cost to the NHS pension scheme of £Nil.

9 Pensions Costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018 is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

10. Finance income

	2017/18 £000	2016/17 £000
Interest from bank accounts	**19**	15

11. Intangible assets

Software licences	**2017/18 £000**	2016/17 £000
Gross cost at 1 April	**1,533**	1,528
Additions	**512**	5
Disposals	**-**	-
Gross cost at 31 March	**2,045**	1,533
Amortisation at 1 April	**1,123**	860
Provided during the year	**207**	263
Amortisation at 31 March	**1,330**	1,123
Net book value		
Purchased assets at 1 April	**410**	668
Purchased assets at 31 March	**715**	410

12. Property, plant and equipment

12.1 Property, plant and equipment at 31 March 2018	Land £000	Buildings £000	Assets under construction £000	Plant and machinery £000	Information technology £000	Total £000
Cost or valuation at 1 April 2017	3,930	33,240	1,854	13,212	3,901	**56,137**
Additions - purchased	-	562	1,105	661	322	**2,650**
Additions - donated	-	16	-	132	-	**148**
Reclassifications	-	983	(983)	-	-	**-**
Impairments recognised in operating expenses	-	(507)	-	-	-	**(507)**
Reversal of impairments	208	481	-	-	-	**689**
Impairments recognised in revaluation reserve	-	(26)	-	-	-	**(26)**
Revaluation	1,312	1,368	-	-	-	**2,680**
Accumulated depreciation transferred on revaluation	-	(1,309)	-	-	-	**(1,309)**
Disposals	-	-	-	-	-	**-**
At 31 March 2018	**5,450**	**34,808**	**1,976**	**14,005**	**4,223**	**60,461**
Depreciation at 1 April 2017	-	-	-	10,169	2,099	**12,268**
Provided during the year	-	1,309	-	1,016	304	**2,630**
Accumulated depreciation transferred on revaluation	-	(1,309)	-	-	-	**(1,309)**
Disposals	-	-	-	-	-	**-**
Depreciation at 31 March 2018	**-**	**-**	**-**	**11,185**	**2,403**	**13,588**
Net book value						
Purchased assets as at 1 April 2017	3,930	31,222	1,854	2,779	1,783	**41,568**
Donated assets as at 1 April 2017	-	2,018	-	264	19	**2,301**
Total at 1 April 2017	**3,930**	**33,240**	**1,854**	**3,043**	**1,802**	**43,869**
Purchased assets as at 31 March 2018	5,450	32,750	1,976	2,545	1,809	**44,531**
Donated assets as at 31 March 2018	-	2,058	-	274	10	**2,342**
Total at 31 March 2018	**5,450**	**34,808**	**1,976**	**2,820**	**1,820**	**46,873**

12.1 Property, plant and equipment (continued)						
2016/17 comparators	**Land £000**	**Buildings £000**	**Assets under construction £000**	**Plant and machinery £000**	**Information technology £000**	**Total £000**
Cost or valuation at 1 April 2016	4,140	31,794	3,339	12,455	2,234	**53,962**
Additions - purchased	-	924	1,371	745	11	**3,051**
Additions - donated	-	-	-	12	6	**18**
Reclassifications	-	1,206	(2,856)	-	1,650	**-**
Impairments recognised in operating expenses	(208)	(1,463)	-	-	-	**(1,671)**
Reversal of impairments	-	599	-	-	-	**599**
Impairments recognised in revaluation reserve	(2)	(764)	-	-	-	**(766)**
Revaluation	-	2,162	-	-	-	**2,162**
Accumulated depreciation transferred on revaluation	-	(1,218)	-	-	-	**(1,218)**
Disposals	-	-	-	-	-	**0**
At 31 March 2017	**3,930**	**33,240**	**1,854**	**13,212**	**3,901**	**56,137**
Depreciation at 1 April 2016	-	-	-	9,184	1,858	**11,042**
Provided during the year	-	1,218	-	985	241	**2,444**
In-year depreciation transferred on revaluation	-	(1,218)	-	-	-	**(1,218)**
Disposals	-	-	-	-	-	**0**
Depreciation at 31 March 2017	**-**	**-**	**-**	**10,169**	**2,099**	**12,268**
Net book value						
- Purchased assets as at 1 April 2016	4,140	29,583	3,339	2,897	356	**40,315**
- Donated assets as at 1 April 2016	-	2,211	-	374	20	**2,605**
Total at 1 April 2016	**4,140**	**31,794**	**3,339**	**3,271**	**376**	**42,920**
- Purchased assets as at 31 March 2017	3,930	31,222	1,854	2,779	1,783	**41,568**
- Donated assets as at 31 March 2017	-	2,018	-	264	19	**2,301**
Total at 31 March 2017	**3,930**	**33,240**	**1,854**	**3,043**	**1,802**	**43,869**

12.2 Fully depreciated assets

Fully depreciated assets with an aggregate gross carrying value of £10,546,000 were in use at 31 March 2018.

12.3 Property, plant and equipment donated during the year

The League of Friends of the Queen Victoria Hospital and the Queen Victoria NHS Trust Charitable Fund donated capital items with a combined value of £148,000.

13. Capital commitments

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

Capital commitments	**31 March 2018 £000**	31 March 2017 £000
Property, plant and equipment	**698**	193

14. Inventories

Inventories at 31 March	31 March 2018 £000	31 March 2017 £000
Drugs	**112**	109
Consumables	**1,067**	320
Total	**1,178**	429

15. Trade and other receivables

15.1 Trade and other receivables comprise	31 March 2018 Current £000	31 March 2017 Current £000
NHS and other related party receivables	**4,660**	2,727
Accrued income	**3,183**	3,392
Provision for the impairment of receivables	**(788)**	(798)
Prepayments	**692**	617
Other receivables	**1,423**	1,445
Total	**9,169**	7,383

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 2018 £000	31 March 2017 £000
By up to three months	**3,216**	986
By between three and six months	**17**	465
By more than six months	**678**	661
Total	**3,911**	2,112

15.3 Provision for impairment of NHS receivables	2017/18 £000	2016/17 £000
Balance at 1 April	**(504)**	(908)
Amount recovered or written off during the year	**242**	516
Increase in receivables impaired	**(299)**	(112)
Balance at 31 March	**(561)**	(504)

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	2017/18 £000	2016/17 £000
Balance at 1 April	**(294)**	(316)
Amount recovered or written off during the year	**12**	58
Increase in receivables impaired	**55**	(36)
Balance at 31 March	**(227)**	(294)

16. Cash and cash equivalents

	2017/18 £000	2016/17 £000
Balance at 1 April	**7,784**	7,285
Net change in year	**1,130**	499
Balance at 31 March	**8,914**	7,784'
Comprising:		
Cash with the Government Banking Service (GBS)	**8,779**	7,739
Commercial banks and cash in hand	**135**	45
Cash and cash equivalents as in statement of cash flows	**8,914**	7,784

17. Trade and other payables

	31 March 2018 £000	31 March 2017 £000
NHS payables	**3,349**	2,667
Trade payables – capital	**936**	1,202
Other payables – revenue	**1,642**	805
Accruals	**1,894**	1,226
	7,821	5,900
Tax and social security costs	**1,081**	887
Total	**8,902**	6,787

NHS payables include £591,000 outstanding pensions contributions at 31 March 2018 (31 March 2016 £557,000).

18. Deferred income

Current	31 March 2018 £000	31 March 2017 £000
Total	**166**	164

19. Provisions

Current	31 March 2018 £000	31 March 2017 £000
Pensions relating to staff	**27**	27
Legal claims	**13**	16
Total	**40**	43

Non-current	31 March 2018 £000	31 March 2017 £000
Pensions relating to staff	**625**	641

Movements in-year	Pensions relating to staff £000	Legal claims £000	Other £000	Total £000
At 1 April 2017	668	16	-	**684**
Change in discount rate	11	-	-	**11**
Arising during the year	-	-	-	**-**
Used during the year	(27)	(3)	-	**(30)**
Reversed unused	-	-	-	**-**
Unwinding of discount	1	-	-	**1**
At 31 March 2018	652	13	-	**665**

Expected timing of cash flows:				
Within one year	27	13	-	**40**
Between one and five years	98	-	-	**98**
After five years	527	-	-	**527**
	652	13	-	**665**

The provision for pensions relating to staff consists of £612,000 in respect of injury benefit (31 March 2017 £618,000) and £40,000 in respect of early retirements (31 March 2017 £50,000). 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 liability is limited to £3,000 or £10,000 depending on the nature of the case. The remainder is borne by the scheme. The provision is shown net of any reimbursement due from the NHSLA.

£2,668,000 was included in the provisions of the NHS Resolution at 31 March 2018 in respect of clinical negligence liabilities of the Trust (31 March 2017 £2,491,000 (NHS Litigation Authority)).

20. Finance expense

Interest expense	31 March 2018 £000	31 March 2017 £000
Loans from the Foundation Trust Financing Facility (Department of Health)	**195**	217

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 2018 £000**	31 March 2017 £000
Loans and receivables:		
NHS and other related party receivables	**4,660**	2,727
Accrued income	**3,183**	3,392
Other receivables	**592**	1,416
Cash at bank and in hand	**8,914**	7,784
Total	**17,349**	15,319

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 2018 £000**	31 March 2017 £000
Carrying value:		
Borrowings	**6,600**	7,378
Trade and other payables	**5,919**	4,563
Accrued expenditure	**1,841**	1,208
Total	**14,360**	13,149

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

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

Other tax and social security cost amounts of £1,030,000 (2016/17 £887,000) and deferred income of £166,000 (2016/17 £164,000) 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 £5,823,000 portion of the borrowings that falls due after more than one year.

21.4 Derivative financial instruments

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

21.5 Financial risk management

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

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

Currency risk

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

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposure as at 31 March 2018 are in receivables from customers, as disclosed in note 15.

Liquidity risk

The Trust's operating costs are incurred under contracts with NHS England and Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust is not, therefore, exposed to significant liquidity risks.

22. Related party transactions

No board members or members of the key management staff or parties related to them undertook any transactions with Queen Victoria Hospital NHS Foundation Trust during 2017/18 (2016/17 none).

The Department of Health and Social Care is the parent department, other public sector bodies included within the Whole of Government Accounts are also deemed to be related parties. The Trust has financial transactions with many such bodies.

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

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

	2017/18		2016/17	
	Income £000	**Expenditure £000**	Income £000	Expenditure £000
The Queen Victoria Hospital NHS Trust Charitable Fund	**126**	**-**	30	-

Whole of Government Accounts bodies	2017/18		2016/17	
Bodies with whom either income or expenditure exceeded £100,000 during the year:	**Income £000**	**Expenditure £000**	Income £000	Expenditure £000
Income and expenditure				
Brighton and Sussex University Hospitals NHS Trust	**134**	**925**	194	951
Guy's and St Thomas' NHS Foundation Trust	**80**	**13**	100	14
Maidstone and Tunbridge Wells NHS Trust	**139**	**48**	158	82
Dartford and Gravesham NHS Trust	**-**	**774**	-	751
Medway NHS Foundation Trust	**5**	**1,091**	30	1,039
East Sussex Healthcare NHS Trust	**0**	**683**	-	600
Sussex Community NHS Foundation Trust	**175**	**11**	190	13
Surrey And Sussex Healthcare NHS Trust	**59**	**133**	53	15
East Kent Hospitals University NHS Foundation Trust	**-**	**103**	-	106
Northumbria Healthcare NHS Foundation Trust	**-**	**106**	-	121
NHS Resolution (NHS Litigation Authority)	**-**	**486**	-	365
Care Quality Commission	**-**	**116**	-	78
Health Education England	**1,495**	**7**	1,651	4
NHS England	**24,363**	**-**	23,127	8
NHS Ashford CCG	**521**	**-**	462	-
NHS Bexley CCG	**331**	**-**	412	-
NHS Brighton and Hove CCG	**1,223**	**-**	1,086	-
NHS Bromley CCG	**661**	**-**	608	-
NHS Canterbury and Coastal CCG	**675**	**-**	712	-
NHS Coastal West Sussex CCG	**2,813**	**-**	2,570	-
NHS Crawley CCG	**2,118**	**-**	1,930	-
NHS Croydon CCG	**265**	**-**	235	-
NHS Dartford Gravesham and Swanley CCG	**2,406**	**-**	2,570	-
NHS East Surrey CCG	**2,713**	**-**	2,577	-
NHS Eastbourne Hailsham and Seaford CCG	**1,330**	**-**	1,120	-
NHS Guildford and Waverley CCG	**619**	**-**	510	-
NHS Hastings and Rother CCG	**1,689**	**-**	1,746	-
NHS High Weald Lewes Havens CCG	**3,781**	**-**	3,697	-
NHS Horsham and Mid Sussex CCG	**6,074**	**-**	6,284	-
NHS Medway CCG	**2,573**	**-**	2,727	-
NHS North West Surrey CCG	**196**	**-**	228	-
NHS South Kent Coast CCG	**660**	**-**	743	-
NHS Surrey Downs CCG	**759**	**-**	798	-
NHS Swale CCG	**1,001**	**-**	1,060	-
NHS Thanet CCG	**365**	**-**	416	-
NHS West Kent CCG	**5,665**	**-**	5,769	-
HM Revenue & Customs (apprenticeship levy and Employer NI contributions)	**-**	**3,756**	-	3,406
NHS Pension Scheme (Employer contributions)	**-**	**4,052**	-	3,942
	64,889	**12,273**	63,763	11,495

22. Related party transactions (cont.)

	31 March 2018		31 March 2017	
	Receivables £000	**Payables £000**	Receivables £000	Payables £000
Receivables and payables				
Brighton and Sussex University Hospitals NHS Trust	**467**	**697**	469	590
Guy's and St Thomas' NHS Foundation Trust	**28**	**6**	35	9
Maidstone and Tunbridge Wells NHS Trust	**103**	**14**	135	74
Dartford and Gravesham NHS Trust	**7**	**347**	7	92
Medway NHS Foundation Trust	**92**	**774**	125	654
East Sussex Healthcare NHS Trust	**0**	**258**	-	73
Sussex Community NHS Foundation Trust	**45**	**2**	2	7
Surrey And Sussex Healthcare NHS Trust	**334**	**22**	265	51
East Kent Hospitals University NHS Foundation Trust	**-**	**11**	-	11
Northumbria Healthcare NHS Foundation Trust	**-**	**36**	-	18
NHS Resolution (NHS Litigation Authority)	**-**	**-**	-	-
Care Quality Commission	**-**	**-**	-	-
Health Education England	**1,154**	**7**	14	-
NHS England	**2,765**	**10**	1,287	339
NHS Ashford CCG	**86**	**-**	49	-
NHS Bexley CCG	**-**	**34**	42	-
NHS Brighton and Hove CCG	**182**	**-**	11	-
NHS Bromley CCG	**21**	**-**	4	-
NHS Canterbury and Coastal CCG	**-**	**38**	-	47
NHS Coastal West Sussex CCG	**70**	**-**	471	-
NHS Crawley CCG	**57**	**-**	248	-
NHS Croydon CCG	**141**	**-**	16	4
NHS Dartford, Gravesham and Swanley CCG	**-**	**283**	17	-
NHS East Surrey CCG	**-**	**40**	-	72
NHS Eastbourne, Hailsham and Seaford CCG	**219**	**-**	-	162
NHS Guildford and Waverley CCG	**14**	**-**	12	-
NHS Hastings and Rother CCG	**-**	**261**	35	-
NHS High Weald Lewes Havens CCG	**114**	**6**	444	15
NHS Horsham and Mid Sussex CCG	**101**	**-**	701	-
NHS Medway CCG	**-**	**131**	70	26
NHS North West Surrey CCG	**57**	**-**	42	-
NHS South Kent Coast CCG	**-**	**14**	26	-
NHS Surrey Downs CCG	**63**	**-**	26	14
NHS Swale CCG	**37**	**-**	18	-
NHS Thanet CCG	**-**	**81**	13	-
NHS West Kent CCG	**-**	**17**	148	-
HM Revenue & Customs (apprenticeship levy and NI contributions)	**-**	**1,030**	-	887
NHS Pension Scheme	**-**	**598**	-	557
	6,159	**4,718**	4,732	3,702

23. Intra-government and other balances

Receivables: amounts falling due within one year	31 March 2018 £000	31 March 2017 £000
Balances with NHS bodies	**7,309**	5,700
Balances with other government bodies	**300**	557
Balances with bodies external to government	**2,349**	1,924
Provision for the impairment of receivables	**(788)**	(798)
	9,169	7,383

Payables: amounts falling due within one year	31 March 2018 £000	31 March 2017 £000
Balances with NHS bodies	**3,175**	2,328
Balances with other government bodies	**1,729**	1,511
Balances with bodies external to government	**3,998**	2,948
	8,902	6,787

24. Losses and special payments

Losses and special payments are calculated on an accruals basis.

There were 82 cases of losses and special payments totalling £8,000 during 2017/18, (48 cases totalling £31,000 in 2016/17).

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

There were no fraud cases within these losses.

Losses and Special Payments	31 March 2018 No.	31 March 2018 £000	31 March 2017 No.	31 March 2017 £000
Losses - Bad Debts and claims abandoned	**65**	**7**	36	1
Losses - Fruitless payments and constructive losses	**0**	**-**	3	1
Losses - Stores Losses	**0**	**-**	1	27
Special Payments - Ex gratia payments	**17**	**1**	8	2
	82	**8**	48	31

25. Third party assets

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

Appendices

"QVH is an exceptional place both to recieve treatment and to work"

7.1 Board of directors register

Name, title and appointment	Meeting attendance and role 2017/18						
	Board of directors	Audit committee	Nomination & remuneration committee	Finance and performance committee	Quality & governance committee	Council of governors	QVH Charity
Ginny Colwell Non-Executive Director 21 April 2016 to 20 April 2019	9 of 11 (Member)	5 of 6 (Member)	2 of 3 (Member)	NA	6 of 6 (Chair)	4 of 4 (Attendee)	NA
Kevin Gould Non-Executive Director 1 September 2017 to 30 August 2020	7 of 7 (Member)	3 of 3 (Chair)	2 of 2 (Member)	7 of 7 (Member)	NA	2 of 2 (Attendee)	NA
Beryl Hobson Chair 1 April 2015 to 31 March 2018	11 of 11 (Chair)	NA	3 of 3 (Chair)	10 of 11 (Member)	NA	4 of 4 (Chair)	3 of 4 (Member)
Steve Jenkin Chief Executive 14 November 2016 to present	11 of 11 (Member)	NA	NA	10 of 11 (Member)	5 of 6 (Member)	4 of 4 (Attendee)	NA
Sharon Jones Director of Operations 1 June 2015 to 9 April 2018	11 of 11 (Member)	NA	NA	8 of 11 (Member)	5 of 6 (Member)	4 of 4 (Attendee)	NA
Gary Needle Non-Executive Director 1 July 2017 to 30 June 2020	8 of 8 (Member)	NA	2 of 2 (Member)	NA	2 of 4 (Member)	3 of 3 (Attendee)	3 of 4 (Chair)
Jason McIntyre Acting Director of Finance and performance 11 September 2017 to 31 January 2018	3 of 4 (Member)	NA	NA	4 of 4 (Member)	2 of 4 (Member)	2 of 2 (Attendee)	2 of 2 (Member)
Michelle Miles Director of Finance and performance 1 February 2018 to present	1 of 1 (Member)	NA	NA	2 of 2 (Member)	1 of 1 (Member)	0 of 0 (Attendee)	1 of 1 (Member)
Geraldine Opreshko Director of Workforce and organisational development 26 July 2017 to present	10 of 11 (Member)	NA	NA	8 of 11 (Member)	3 of 6 (Member)	4 of 4 (Attendee)	1 of 1 (Attendee)
Ed Pickles Medical Director 1 October 2016 to 30 September 2019	11 of 11 (Member)	NA	NA	NA	3 of 6 (Member)	3 of 4 (Attendee)	1 of 4 (Member)
Clare Pirie Director of Communications and corporate affairs 1 May 2017 to present	11 of 11 (Member)	NA	NA	NA	NA	4 of 4 (Attendee)	4 of4 (Attendee)
Lester Porter Non-Executive Director and Senior Independent Director 1 September 2011 to 31 August 2017	3 of 3 (Member)	2 of 2 (Chair)	1 of 1 (Member)	NA	2 of 3 (Member)	1 of 2 (Attendee)	1 of 1 (Chair)
Clare Stafford Director of Finance and Performance 1 June 2015 to present	4 of 4 (Member)	NA	NA	4 of 5 (Member)	3 of 3 (Member)	2 of 2 (Attendee)	1 of 1 (Member)
Jo Thomas Director of Nursing and Quality 1 February 2015 to present	9 of 11 (Member)	NA	NA	NA	6 of 6 (Member)	4 of 4 (Attendee)	NA
John Thornton Non-Executive Director 1 October 2013 to 30 September 2019, and Senior Independent Director from 1 September 2017	11 of 11 (Member)	3 of 5 (Member)	2 of 3 (Member)	10 of 11 (Chair)	NA	3 of 4 (Attendee)	NA

7.2 Council of governors register

Name	Constituency	Status of current term	Start of term	End of term	Meeting attendance
Beesley, Brian	Public	Re-elected 2nd term	01/07/2014	30/06/2017	1 of 1
Belsey, John	Public	Re-elected 2nd term	01/07/2017	30/06/2020	3 of 4
Bennett, Liz	Stakeholder[2]	Appointed	01/07/2013	30/06/2018	2 of 4
Brown, St John	Stakeholder[3]	Appointed	01/04/2017	31/03/2020	3 of 4
Burkhill-Prior, Wendy	Public	Elected 1st term	01/07/2016	30/06/2019	4 of 4
Cunnington, Jenny	Public	Re-elected 2nd term	01/07/2014	30/06/2017	1 of 1
Dabell, John	Public	Re-elected 2nd term	01/07/2014	30/06/2017	1 of 1
Dudgeon, Robert	Public	Re-elected 2nd term	01/07/2016	30/06/2019	4 of 4
Fulford-Smith, Antony	Public	Elected 1st term	01/07/2017	30/06/2019	3 of 3
Glynn, Angela	Public	Re-elected 2nd term	01/07/2017	30/06/2020	1 of 4
Haite, Janet	Public	Elected 1st term	01/07/2017	30/06/2020	3 of 3
Halloway, Chris	Public	Elected 1st term	01/07/2015	30/06/2018	4 of 4
Harold, John	Public	Elected 2nd term	01/07/2015	30/06/2018	3 of 4
Higgins, Anne	Public	Re-elected 2nd term	01/07/2014	30/06/2017	1 of 1
Hunt, Douglas	Public	Elected 1st term	01/07/2017	30/06/2020	3 of 3
Lehan, Carol	Staff	Elected 1st term	01/07/2017	30/06/2020	2 of 3
Lockyear, Sandra	Staff	Elected 1st term	01/07/2017	30/06/2020	2 of 3
McGarry, Joe	Public	Elected 1st term	01/07/2017	30/06/2020	2 of 3
Martin, Tony	Public	Elected 1st term	01/07/2014	30/06/2017	4 of 4
Mockford, Julie	Staff	Re-elected 2nd term	01/07/2017	30/06/2020	3 of 4
Orman, Christopher	Public	Re-elected 2nd term	01/07/2014	30/06/2017	1 of 1
Rashid, Mansoor	Staff	Elected 1st term	01/07/2014	30/06/2017	0 of 1
Roche, Glynn	Public	Elected 1st term	01/07/2017	30/06/2020	3 of 4
Santi, Gillian	Public	Re-elected 2nd term	01/07/2014	30/06/2017	0 of 1
Shaw, Michael	Public	Re-elected 2nd term	01/07/2014	30/06/2017	1 of 1
Shore, Peter	Public	Elected 1st term	01/07/2016	30/06/2019	4 of 4
Webster, Norman	Stakeholder[4]	Appointed	01/07/2011	Ongoing	2 of 4
Wiggins, John	Public	Elected 1st term	01/07/2017	30/06/2020	3 of 3
Wilson, Mickola	Public	Elected 1st term	01/07/2017	30/06/2020	1 of 3
Wickenden, Peter	Public	Re-elected 2nd term	01/07/2014	30/06/2017	1 of 1

[1] Nominated Lead Governor

[2] Representing West Sussex County Council

[3] Representing QVH League of Friends

[4] Representing East Grinstead Town Council

7.3 Directors' biographies 2017/18

Ginny Colwell, Non-Executive Director

Ginny originally trained as a nurse and worked at Great Ormond Street Hospital, leaving there as deputy director of nursing to become director of nursing at the Royal Surrey County Hospital. Ginny then became corporate head of nursing for Nuffield Hospitals before being appointed head of nursing for Surrey and Sussex Strategic Health Authority. Ginny has also been a founder non-executive director at Central Surrey Health, acting as chair for her last three months, and vice chair of Phyllis Tuckwell Hospice. Ginny currently works independently as an individual and organisational coach, and as a board advisor to Richmond and Hounslow Community Trust.

Kevin Gould, Non-Executive Director

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

Beryl Hobson, Chair

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

Steve Jenkin, Chief Executive

Steve Jenkin joined the Trust in November 2016. He was previously the chief executive of Peninsula Community Health, providing services across Cornwall and the Isles of Scilly including running 14 community hospitals. Prior to that Steve was director of health and social care with national charity Sue Ryder, and chief executive of Elizabeth FitzRoy Support, a national charity supporting people with learning disabilities. Steve has an MBA through the Open University.

Sharon Jones, Director of Operations (non-voting director)

Sharon has worked in the NHS since 1983, when she firstly trained as a nurse and then as a podiatrist. For the first 18 years of her career she worked in South East London where she held several clinical posts and had an interest in diabetes and the diabetic foot/vulnerable lower limb, before moving into operational management. Prior to joining QVH in 2015, Sharon worked for 12 years as a director in community, acute and commissioning organisations across Kent and South West London, before becoming QVH's director of operations in 2015.

Jason McIntyre, Acting Director of Finance and Performance

Jason McIntyre took up the position of acting director of finance and performance in September 2017. He has previously held a number of senior finance roles in London-based acute Trusts including Croydon Health Services, and Bart's Health NHS Trust. Jason is a CIMA qualified accountant and started his NHS career in January 1996. He joined QVH in June 2015 as deputy director of finance.

Michelle Miles, Director of Finance and Performance

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

Gary Needle, Non-Executive Director

Gary Needle joined the board in July 2017. He has over 35 years' experience in health care executive management including posts as a chief executive in Brighton and Hove and as a director at the national quality inspectorate. He has recently returned to the UK from Qatar, where he was director of planning for the national health care system. Gary is chair of the board of trustees at East Grinstead Sports Club Ltd. At QVH, Gary chairs the charity committee and sits on the quality and governance committee.

Geraldine Opreshko, Director of Workforce and Organisational Development (non-voting director)

Geraldine has worked across health and social care since 1994, initially as a teacher/trainer, and holds an MSc in People and Organisational Development. She has held board level positions in the NHS since 2004 covering workforce, organisational development and transformation. Geraldine has worked across the East and South East of England including Bedfordshire, Norfolk, Cambridge and Kent in acute and community settings before joining QVH in May 2016.

Dr Edward Pickles, Medical Director

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

Clare Pirie, Director of Communications and Corporate Affairs (non-voting director)

Clare joined QVH in 2016. She has been supporting clear communication in the NHS since 2000, working at Kings College Hospital and Brighton and Sussex Universities Hospitals, as well as for national and local NHS commissioning organisations.

Lester Porter, Non-Executive Director and Senior Independent Director

Lester Porter was appointed to the board in September 2011. He has his own executive coaching practice working with individual executives and company boards. Lester's experience includes 15 years as an 'angel' investor in start-up businesses and chair and non-executive director positions on the boards of a number of these companies. From 2006 until 2013 he was chair of an £800 million pension fund. Previously, Lester spent 30 years in a variety of management roles in the healthcare, publishing, financial services and travel sectors and was latterly with the Thomas Cook Group as corporate development director. At QVH Lester chaired the audit committee and the charity committee until he stepped down in August 2017.

Clare Stafford, Director of Finance and Performance

Clare was appointed in June 2015 from West Hertfordshire Hospitals NHS Trust where she was director of operational finance and efficiency. Clare has worked in the NHS for 20 years, having begun her career on the NHS financial management training scheme. During her career she has worked in senior finance roles at Hertfordshire Partnership NHS Trust and Bart's and the London NHS Trust. Clare left the Trust in September 2017.

Jo Thomas, Director of Nursing and Quality

Jo Thomas was appointed in June 2015 having previously held the post in an interim capacity since February 2015. Before joining QVH, Jo held chief nurse positions in both commissioning and acute provider organisations. Jo trained at Brighton University Hospitals NHS Trust and has 33 years of nursing experience in elective, specialist and emergency care, with a specialist interest and an MSc in women's health. She has senior management experience of leading and managing specialist services as well as extensive involvement in operational delivery and the redesign of health care services.

John Thornton, Non-Executive Director

John has almost 30 years' experience as a senior executive in the financial services industry. He is involved in a range of business and community activities as a consultant, non-executive director and mentor. At QVH John chairs the finance and performance committee.