Queen Victoria Hospital
NHS Foundation Trust

Annual Report, Quality Accounts and Financial Accounts **2012/13**

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

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1.1 Chairman's introduction

I am pleased to present the 2012/13 annual report, quality accounts and financial accounts for Queen Victoria Hospital NHS Foundation Trust.

Over the past 12 months, QVH has continued to provide patients with care that is regarded as among the best in the country. Demonstrating the organisation's values of humanity, pride and continuous improvement, the hospital's expert and committed staff have achieved the highest standards of clinical quality, patient experience and safety.

At the same time, the hospital has taken significant strides in securing its position as a national centre of excellence for reconstructive surgery and rehabilitation and a provider of non-complex services for local people.

In March, the board approved the business case for the construction of a further four new theatres, in addition to the six new theatres due to open in the summer of 2013. This means that we will be able to realise our long-held ambition to replace all of our old theatres with brand new facilities.

The new facilities will provide a much better experience for patients. They are at the heart of a wider programme of site developments to update our aging estate, which is costly to maintain, and help guarantee a secure and independent future for the hospital in East Grinstead.

This year saw the publication of the Francis Report into the care provided by Mid Staffordshire NHS Foundation Trust. At QVH, providing safe, effective, dignified care is our priority. We have well-established processes for reviewing and acting upon patient safety, clinical effectiveness and patient experience across all of our services. The board takes an active role, including reviewing all patient safety and quality data, analysis and feedback every month.

However, we can never become complacent about patient care. We have been studying the findings of the report in detail to see where there may be opportunities to further improve the high standards of care we offer our patients.

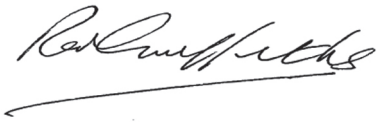
Looking ahead, 2013/14 is a significant year for QVH. We will commemorate our 150th anniversary with the opening of our new theatres and other events. We will also welcome a new chief executive to lead QVH through the next chapter of its development.

On behalf of the board, I extend my congratulations and sincere thanks to our departing chief executive Adrian Bull. He leaves QVH with a strong management team and board of directors that have a clear agenda for maintaining and enhancing the hospital's success over the coming years.

I would also like to thank Ken Lavery who retires as medical director after six years in the role and over 20 years at the hospital. His strong leadership has underpinned the hospital's many achievements and excellent clinical reputation.

Lastly I must offer our condolences to the family and friends of public governor Jonathon Street who sadly died this year.

With the arrival of a new chief executive, medical director and non-executive colleagues, I have, on the invitation of the council of governors, agreed to extend my contract as chairman to March 2015. I look forward to continuing to work with the professional and dedicated directors, governors and staff of QVH as we further build on their tremendous achievements of the last year.



Peter Griffiths
Chairman

1.2 Chief Executive's introduction

At QVH we aim to combine clinical excellence with a strong culture of personal care for everyone we treat. As this report demonstrates, we have made good progress in achieving our objectives over the last year.

The commitment and dedication of staff in all parts of the hospital ensure that QVH continues to offer high quality care to patients from across the region who come to us for our specialist expertise, as well as to local people who benefit from non-complex treatments in our areas of specialism. The hospital continues to provide other important local services such as diagnostics, therapies, and a minor injuries unit.

During the year we received excellent results in the national NHS inpatient survey. We scored particularly well on questions about the quality of doctors, nurses, care and treatment and many of the results were the highest of any trust in the country. In the staff survey we also achieved the best results nationally for staff recommendation of the trust as a place to work or receive treatment and for staff job satisfaction.

In common with other organisations, we have continued to improve the efficiency and productivity of our services, focussing on careful management of costs and continuous improvement of our structures and processes. This is resulting, for example, in less complicated booking and administration systems which benefit both patients and staff.

The hospital has already embarked on the replacement of six of its aged theatres. Due to the hospital's sound financial performance, we are now able to complete the replacement by building the remaining four new theatres without adding to the original loan.

Amanda Parker
Director of Nursing and Quality

At the time of preparing the 2012/13 annual report, the position of chief executive was vacant, pending appointment from 1 July 2013. As part of the trust's interim leadership arrangements, the board of directors agreed that its Director of Nursing and Quality, Amanda Parker, would act as accounting officer for the purposes of this annual report.

Overview of 2012/13 2

2.1 Our proud achievements

High quality patient care

- Our specialist services continue to record excellent clinical outcomes for patients, compared with national and international benchmarks and averages.
- Results from the 2012 national NHS inpatient survey showed that QVH is one of the best hospitals in the eyes of patients. We achieved the highest score in the country for how well patients rate their experience of being in hospital.
- In the 2012 national NHS staff survey we scored the best results nationally for staff recommendation of the trust as a place to work or receive treatment, and for job satisfaction.
- Our own regular surveys of inpatients show that over 90% would be happy to recommend the hospital to their family or friends.
- We have achieved 100% of our Commissioning for Quality and Innovation (CQUIN) targets which included:
  - improving responsiveness to the individual needs of patients
  - going further in tackling venous-thromboembolism (VTE)
  - implementing the 'sit and see' project to improve care for our elderly patients
  - assessing trauma patients for their risk of dementia
  - improving elective consent prior to the day of surgery
  - delivering better quality, outcomes and productivity through the use of new technology.
- We continue to have a zero-tolerance approach to hospital-acquired infection and had no cases of Clostridium difficile this year.
- Our Mohs skin cancer surgery team and a therapist nominated by a patient were runners up in the Sussex 2012/13 'Proud to Care' awards.

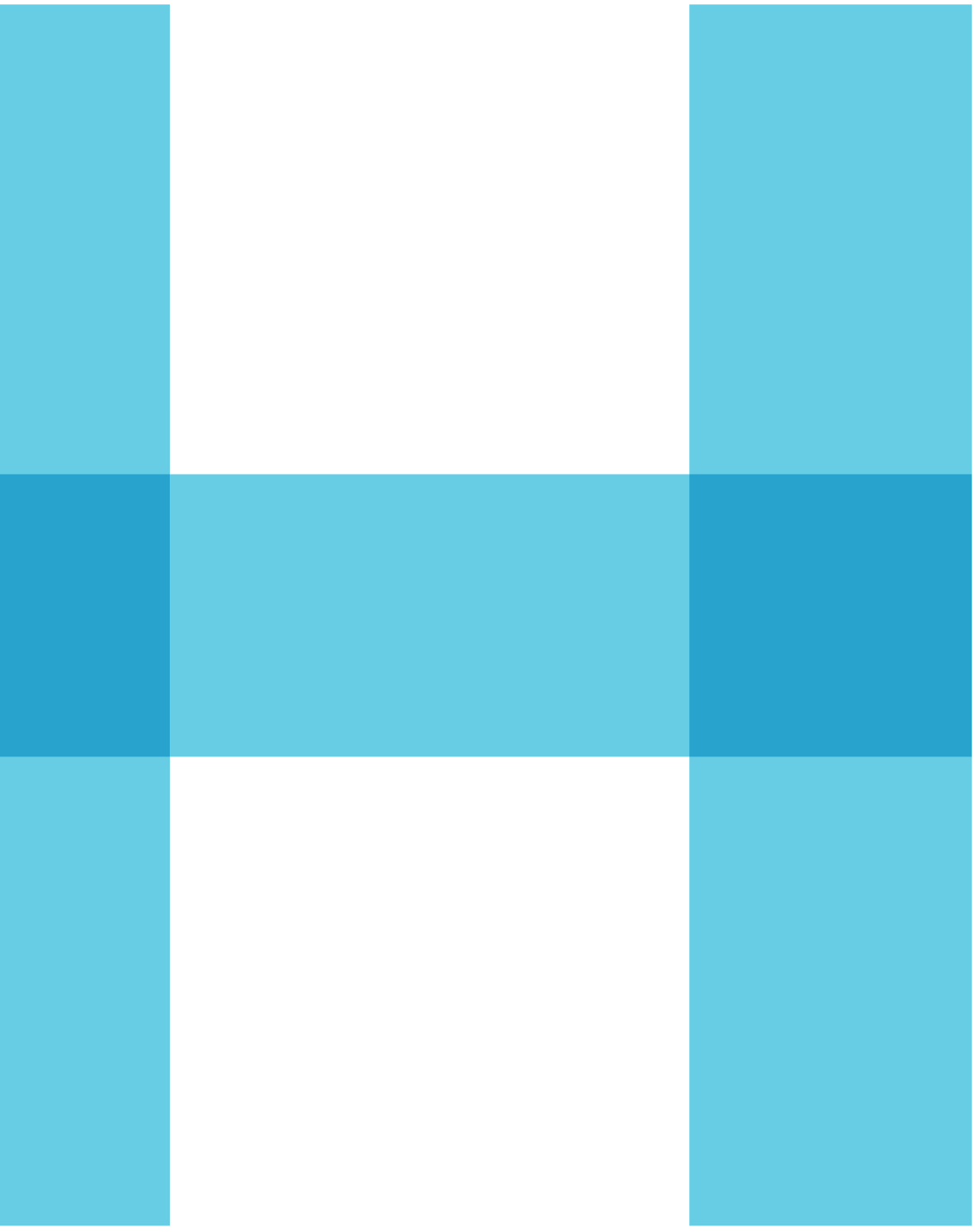
More patients receiving essential care

- We provided life-saving and life-changing treatment and care to tens of thousands of people during the last year, including:
  - 18,000 inpatients
  - 167,000 outpatient appointments
  - 12,000 people who attended our MIU.
- We continue to treat trauma patients sooner by improving the way we run our services and investing in technology such as:
  - upgrading the trust's innovative telemedicine referral system
  - introducing an electronic system to manage trauma surgery capacity
  - hand-held technology to make access to outpatient and inpatient services faster.

Financial stability and investment

- A continued good financial performance has enabled us to invest £8.5m in new equipment and facilities including:
  - significant progress in the building of six new operating theatres
  - laying foundations for an additional four new operating theatres
  - further improvement to the estate infrastructure such as a new patient drop-off area for outpatients
  - £0.4m invested in new medical equipment
  - £0.4m investment in technology to improve patient pathways such as self-check-in and electronic calling systems and patient information screens for outpatients.

Directors report 3



3.1 Directors overview

Who we are and what we do

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

Our world-leading clinical teams also treat common conditions of the hands, eyes, skin and teeth for the people of East Grinstead and the surrounding area. In addition we provide a minor injuries unit, expert therapies and a sleep 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 is a regional and national centre for maxillofacial, reconstructive plastic and corneoplastic surgery, as well as for the treatment of burns. It is a surgical centre for skin cancer and for head and neck cancer and provides microvascular reconstruction services for breast cancer patients following, or in association with, mastectomy. It belongs to relevant cancer networks and multi-disciplinary teams in Kent, Surrey, and Sussex.

QVH was authorised as one of the country's first NHS foundation trusts in July 2004. We have around 9,500 public members in Kent, Surrey and Sussex.

In 2012/13, the principal activities of the trust were the provision of:

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

Reconstructive surgery services are also provided by QVH in facilities at other hospital sites across Kent, Surrey and Sussex – in particular at Surrey and Sussex Hospital, Brighton and Sussex University Hospitals, Medway Maritime Hospital, Darent Valley Hospital, Maidstone Hospital, and East Sussex Hospitals.

In 2012/13, the following individuals served as directors of the trust:

Name	Position
Jeremy Beech	Non-Executive Director
Dr Adrian Bull	Chief Executive
Peter Griffiths	Chairman
Richard Hathaway	Executive Director of Finance and Commerce
Dr Renny Leach	Non-Executive Director and Senior Independent Director
Mr Ken Lavery	Medical Director
Amanda Parker	Executive Director of Nursing and Quality
Lester Porter	Non-Executive Director
Shena Winning	Non-Executive Director

A register of terms of office and meeting attendance of the board of directors is provided in annex D. The biographies of the members of the board of directors are provided in annex F.

Operational performance

In 2012/13 the trust again delivered a good performance in both quality and finance. The key national and local operational performance targets were achieved for the year and the emphasis continued on improving the streamlining of patient flow through the hospital. The maximum waiting times for patients were further reduced and the number of patients waiting for treatment has also fallen.

This year we have been working to reduce the waiting times within each of our services, a target which was previously measured at trust-level. We have been successful in improving service line performance against the 18 week waiting target in all of our services.

There were two cases of MRSA infection during the year, against a target limit of one. This, however, is below the *de minimis* number of six cases set by Monitor.

A detailed analysis of the trust's performance against national targets is provided at annex B.

We have continued to achieve high levels of satisfaction among patients. In both our own patient surveys and in the national surveys we score highly on all measures. In particular, over 90% of patients continue to say that they would recommend the hospital as a place of treatment for family and friends. Complaints remain low and letters of compliment on the care experienced by patients are regularly received.

Overall referrals to QVH remained stable again this year and demand for services was strong. The hand surgery service saw increased activity and our therapy services were also busier. The reduction in maxillofacial surgery referrals from Kent following the introduction of a community-based service in that area was offset by an increase in the number of patients requiring more complex surgery.

The numbers of patients waiting for treatment reduced over the year as the trust was able to shorten waiting times to meet the new service line waiting time targets. This led to higher than planned activity levels in some services which may not be repeated in 2013/14. However, the waiting list position is now believed to be sustainable and in line with the performance targets required of the trust.

Financial performance

QVH delivered a very good financial performance in 2012/13 achieving a surplus of £4.225m before impairments. This is the surplus generated by trust performance and used by Monitor for assessing the organisation's financial risk rating.

The trust also undertook an annual asset revaluation exercise at 31 March 2013 and the result of this was to increase some asset values by around £1.7m. These are included in the accounts' statement of comprehensive income which therefore shows a surplus of £5.8m.

The trust's financial performance was improved by a number of factors. There was higher than expected activity with a more complex case mix. This was delivered within existing capacity which meant costs were minimised. The trust received additional income by achieving quality targets and also incurred lower costs than budgeted, particularly depreciation and interest, because the new theatre block will open slightly later than originally anticipated. Not all these benefits will occur again in 2013/14 and the plan for next year will reflect this.

The trust revaluation of assets in March 2013 resulted in a reduction in the carrying value of certain assets. The asset values increased in some categories which led to an additional £1.7m 'positive impairment'. In accordance with the agreed treatment with Monitor, this asset value increase is excluded from the financial risk rating calculation. QVH achieved an overall financial risk rating of 5 (the lowest level of financial risk attainable under Monitor's compliance framework).

The business plan identified a savings requirement of £2m, in line with national efficiency requirements, as well as improved operational efficiency in order to deliver its targets. These targets were achieved in the year.

All figures in £m	Actual 2012/13	Actual 2011/12
Income (excluding reversal of impairments)	58.3	55.8
Pay	(36.3)	(35.8)
Non-pay costs excluding impairments	(16.8)	(16.2)
Interest and dividend	(1.0)	(0.9)
Surplus before impairments and transformation costs	4.2	2.9
Net reversal of impairments	1.7	(1.8)
Transformation costs	(0.1)	(0.4)
Surplus / (deficit)	5.8	0.7
Cash balance	8.1	6.0
Financial risk rating at Q4	5	5

Income

Income from treating patients increased by £1.1m from 2011/12 to £53.7m. This reflected both an increase in the number of patients seen and also a more complex case mix than in previous years, which has more than offset the national tariff decrease this year. This increase also includes the proportion of the trust's income received for achievement of quality targets agreed with commissioners, known as CQUIN income. The trust performed well against these targets in 2012/13 and received around £1m.

The good financial performance reflects a strong demand for the trust's services across the south east. In agreement with its commissioners, the trust also undertook additional activity in 2012/13 to improve the waiting times in individual specialties.

QVH continued to treat a relatively small number of private patients and remained within its private patient income cap for the year until the cap was abolished on 1 October 2012.

Despite the healthy cash balances held, interest income remained low at just £20k given the low national interest rate levels.

Expenditure

Expenditure increased this year, though mainly because more patients were treated and additional staff costs and consumables were required.

Pay costs increased by 1.5% reflecting additional sessions worked as well as the incremental pay increases received by staff progressing through the national pay scales in line with national terms and conditions. However, overall staff numbers were slightly lower than the previous year at 815 (830 in 2011/12) reflecting the efficiency improvements that have been introduced within the trust.

Non-pay costs increased by 3.7%, mainly reflecting additional clinical consumables costs associated with the increased activity.

The investment in the new operating theatres has progressed well in the year and this is shown by the increase in fixed assets. There are however additional costs associated with the investment, which has seen interest payable and public dividend capital (PDC) costs increase in the year. There will be further additional costs when the project is completed in 2013/14.

Cash

The cash position remains reasonably strong with £8.1m at year end.

The trust is borrowing £10.1m from the Foundation Trust Financing Facility to fund the theatre construction and had drawn down £6.5m of the loan by March 2013.

The trust has worked closely with commissioners to minimise the possible disruption to cash flow over the March 2013 year end as primary care trusts are replaced by new NHS bodies including clinical commissioning groups.

3.2 Regulatory ratings

The trust reports to Monitor on a quarterly basis and its 2012/13 ratings are summarised below.

	Q1	Q2	Q3	Q4
Finance	5	5	5	5
Governance	Green	Green	Amber-Green	Green

QVH has met the key performance measures for waiting times for 2012/13 as required by national standards and the Monitor compliance framework, except for achieving the 18 week waiting time target in Q3. This was expected as a consequence of treating patients who had waited longer than 18 weeks when moving to service line compliance with the target, which is a new requirement. This affected the governance rating in Q3 but the target was achieved again in Q4.

QVH also remained within its limit for cases of Clostridium difficile for the year. The trust exceeded the maximum allowable cases of MRSA, having two cases against a target limit of one, but these are below the *de minimis* threshold applied by Monitor and therefore did not count against the governance rating.

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

The CQC provide us with a quality and risk profile to inform our quality and safety activity and ensure compliance with essential standards. The most recent profile shows 'green' for six outcomes and 'low neutral' for five, with no outcomes rated 'amber' or 'red'. For five outcomes, there was insufficient data to calculate a risk estimate.

3.3 Patient care

Delivery of safe and effective care alongside excellent patient experience remains at the heart of QVH's strategy for delivering health care services. How successfully we have achieved this is reflected in our national inpatient and staff surveys results.

Results from the 2012 national NHS inpatient survey showed that QVH is one of the best hospitals in the eyes of patients. We achieved the highest score in the country for how well patients rate their experience of being in hospital. And in the 2012 national NHS staff survey we scored the best results nationally for staff recommendation of the trust as a place to work or receive treatment, and for job satisfaction.

These accolades can only be achieved by having a workforce that is committed to providing great care and to going that extra step to ensure patients are at the heart of all they do.

Waiting times

To further improve services for patients, we have delivered extra clinics and operating sessions to reduce the time patients wait for their outpatient appointment or surgery. As a result, we now have an average waiting time of four weeks for appointments and 10 weeks for surgery.

Specific areas of focus have been within our sleep disorder centre and our corneoplastic unit. We have fully reviewed the care pathway that patients follow in our sleep disorder centre and as a result waiting times have reduced dramatically. We have appointed additional staff to support our corneoplastic service and, by delivering additional work, we have reduced waiting times to meet the 18 week standard.

Care Quality Commission

In February we had an unannounced inspection from the Care Quality Commission (CQC) who assessed five of its outcomes:

- **Outcome 2:** Consent to care and treatment
- **Outcome 4:** Care and welfare of people who use services
- **Outcome 7:** Safeguarding people who use services from abuse
- **Outcome 12:** Requirements relating to workers
- **Outcome 16:** Assessing and monitoring the quality of service provision.

The inspectors were satisfied that we were compliant with these standards. However, they noted that where they did have questions, they were often related to documentation. They therefore chose to add in Outcome 21, relating to record keeping, to the inspection report. Their report identified that actions were required to achieve compliance, although only a minor impact to patients was noted. The trust is taking action to improve record-keeping and documentation.

Patient information

This year we aimed to ensure that patients always receive consistent advice and information from our staff. The results of the national NHS inpatient survey show that we have significantly improved in this regard.

Further availability of information has been developed through the QVH Macmillan Cancer Information Centre which now supports our specialist cancer nurses in providing relevant information to patients. During the year this service expanded its availability. It now provides a weekly information clinic for the local community through the local library to make information about cancer available for everyone.

Specialist nurses

During the year we bid successfully to join a Macmillan-funded pilot project that has enabled us to employ a specialist nurse to support complex discharge management and a support worker to work with the specialist nurses. All our specialist nurses are now affiliated with Macmillan.

The specialist nurse for complex discharges supports the move from hospital to home for our major head and neck cancer patients. Many of these patients return home needing to manage significant change, perhaps because they now have complex wounds, a tracheostomy to allow them to breathe, or need to use a feeding pump to maintain their nutrition.

We recognised that support for these patients as they moved from hospital to home was limited and the specialist nurse for complex discharges now visits them at home and works with their local community teams to ensure a smooth transition. The support worker role has taken some of the administrative burden and as a result allowed specialist nurses to increase the amount of time they spend with patients. The role has also supported awareness campaigns and enabled the greater provision of smoking cessation and healthy living advice on site.

Infection prevention and control

Infection prevention and control is a priority at QVH and monthly compliance assessments cover all aspects of infection prevention and control. These include hand hygiene compliance, use of antibiotics, cleanliness of clinical areas and other compliance against policies.

Against our reduced target limit of one, QVH reported two patients with MRSA bacteraemia. Both of these patients had sustained burn injuries. As a trust that specialises in managing patients with burn injuries we recognise that those with significant burns are particularly vulnerable to acquiring MRSA bacteraemia. In both instances the patients recovered and actions taken to prevent reoccurrence have included staff education on the taking of blood cultures, a uniform review within our burns unit and an enhanced cleaning programme.

Our performance against national targets (see annex B) shows we have met all targets except for MRSA bacteraemia.

Quality of care

Our national Commissioning for Quality and Innovation (CQUIN) targets addressed:

- going further in tackling venous-thromboembolism (VTE)
- improving responsiveness to the individual needs of patients
- assessing trauma patients for their risk of dementia
- implementing the 'safety thermometer'.

The target for VTE was for more than 90% of inpatients to be assessed for their risk of acquiring blood clots (VTE). QVH achieved an average of 92.3% over the year.

Patient experience was assessed using our score for responsiveness to inpatients' personal needs which is an amalgamated score from a number of the national NHS inpatient survey questions. Our score of 84.1 shows that we are meeting our patients' needs well.

Assessing trauma patients for dementia has required us to carry out initial screening of all patients over 75 years of age with an unplanned admission. Where there is a concern on initial screening, a broader assessment is undertaken. Where this still gives cause for concern and suggests a possible diagnosis of dementia, a referral is then made to the relevant healthcare professional for that patient which may be their GP or a hospital physician. At QVH the number of patients who met the requirements for assessment was low (155) however a process has been introduced and over the year 17 patients (94% of those who should have been referred) were referred back to their GP with a potential diagnosis of dementia that had been previously unrecognised.

The 'safety thermometer' is a local improvement tool for measuring, monitoring and analysing aspects of potential harm to patients, including falls, pressure ulcers, catheter associated urinary tract infections and risk of venous thromboembolism. QVH audited all patients each month, reporting the scores back centrally as required.

Targets set locally by our commissioners have been linked to reducing our admission wait for sleep disorder and corneoplastic patients and we have achieved agreed reductions. Other targets have been linked to the CQUIN programme and included:

- implementing the 'sit and see' project to improve care for our elderly patients
- delivering better quality, outcomes and productivity through the use of new technology by implementing the 'innovation health and wealth' high impact innovations
- improving elective consent prior to the day of surgery.

'Sit and see' is an audit process that measures care and compassion. QVH agreed to audit five areas each quarter. This was achieved and results fed back to the areas involved. QVH intends to continue using this programme to evaluate the care and compassion provided to patients and visitors by staff.

QVH was involved in implementing three of the 'innovation health and wealth' high impact innovations:

- Assistive technologies – we continued the rollout of telemedicine across the south and supported rollout for other burns units in Essex and Buckinghamshire.
- Digital by default – we introduced a self-service check-in system across our outpatient departments, enhancing convenience and confidentiality for patients.
- Fluid optimisation – we introduced the use of new equipment to monitor and manage patient blood levels during major surgery.

The taking of consent prior to the day of surgery was also identified as a priority in our quality accounts. We wanted to ensure that patients were well informed prior to the day of their surgery. We have improved on this measure but recognised this was a project that would continue in 2013/14.

Service changes

New services we have introduced this year include:

- Physician clinics that local GPs can use for further assessment of their patients. These clinics offer short waiting times and care closer to the patient's home.
- Margin controlled surgery for skin cancers on specific areas of the face where it is important to preserve as much healthy tissue as possible for reconstruction, known as Mohs surgery. This new service means patients no longer have to travel to London for their care.

In partnership with our commissioners, we have agreed to stop running a gynaecology service from the QVH site and patients now access services at local district general hospitals. This enables all tests, investigations and surgery to be undertaken in a more timely fashion so patients have shorter waiting times and a better experience.

Patient experience

The trust's patient experience manager now acts as a single point of contact for all Patient Advice and Liaison Service (PALS) enquiries, comments, compliments and formal complaints. The role is key to the trust's commitment to ensure that patients have the best possible experience of our care.

A full patient experience annual report for 2012/13, which incorporates data and information about complaints, patient advice and liaison contacts, compliments and other patient experience feedback and activities, is available on our website.

During the course of the year, 73 complaints were investigated by the trust and each complainant received a response that was personally reviewed and signed by the chief executive. Monthly complaints reports are provided to the board of directors and quarterly reports are provided to the quality and risk committee, council of governors and patient experience group.

PALS offers a listening service for patients and immediate assistance with questions, comments, concerns and compliments about care. When people use health services it can be a time of distress and anxiety. PALS can help by giving accurate information, liaising with staff throughout the trust and striving to quickly overcome problems before they escalate.

In 2012/13, we recorded 433 PALS contacts from patients, relatives and the general public.

3.4 Staff engagement

Our approach to staff engagement is founded on the QVH culture and values of 'continuous improvement', 'humanity' and 'pride', all underpinned by 'quality'. This year, our staff have taken time to identify the specific behaviours in their departments and teams which underpin these guiding principles in their daily tasks. Awareness of the impact our values have on patient experience is growing.

Communication is at the forefront of our relationship with staff and their representatives and work through the year has strengthened our formal and informal arrangements. Positive results in the annual staff survey for communications between staff and managers and our overall staff engagement score reflect this work.

Formal consultation with staff continues to be driven through the following:

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

QVH has a strong belief in providing staff with opportunities to contribute to the development of the hospital and the services we provide. We organise monthly staff briefings, walk-rounds by members of the executive team, a fortnightly internal staff newsletter and access to an intranet site.

NHS staff survey 2012

Whilst the staff and patient survey results were very good in 2011 the trust was keen not to become complacent and consequently used the results to develop service-level action plans to address areas for improvement. Areas highlighting staff satisfaction underline the effectiveness of this approach as demonstrated in the latest survey results:

Staff experience	2011 score out of 5	2012 score out of 5
Staff job satisfaction	3.61	3.79
Staff recommendation of the trust as a place to work or receive treatment	4.02	4.24

In taking this approach we have seen year-on-year improvements in the national staff survey and it is therefore pleasing to see that in 2012 our results have once again been very strong.

The survey covers 28 'key findings' and matches our scores against other specialist acute trusts. Overall, 19 of the key findings show QVH to be better than other specialist acute trusts and only one where QVH did not score as well.

One of the most important measures in the survey is the staff engagement score. This combines a number of factors such as ability to contribute to improvements, motivation and whether staff would recommend the trust as a place to work or receive treatment. Staff engagement is scored from 1 to 5 (1 being the minimum and 5 being the maximum) and it was good to see that our score for 2012 had significantly improved on 2011, rising from 3.89 to 4.00.

The table below shows the top and bottom four ranked scores within the survey and compares them against the 2011 results and also the national averages for specialist acute trusts. This helps to show how we are doing against other similar trusts and also where we need to focus our action plans for 2013.

	2011/12		2012/13		
	QVH	National average	QVH	National average	Trust improvement/ deterioration
Response rate	53.0	54.0	62.5	50	+ 9.5
Staff engagement score	3.88	3.77	4.00	3.92	+ 0.12

	2011/12		2012/13		
Top 4 ranking scores	QVH	National average	QVH	National average	Trust improvement/ deterioration
KF23: Staff job satisfaction	3.59	3.55	3.79	3.66	+ 0.20
KF24: Staff recommendation of the trust as a place to work or receive treatment	4.01	3.90	4.24	4.06	+ 0.23
KF21: Percentage of staff reporting good communication between senior management and staff	38%	24%	40%	33%	+ 2%
KF11: Percentage of staff suffering work-related stress in last 12 months	24%	27%	28%	32%	- 4%

	2011/12		2012/13		
Bottom 4 ranking scores	QVH	National average	QVH	National average	Trust improvement/ deterioration
KF18: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	N/A*	N/A*	24%	21%	NA*
KF13: Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	31%	31%	31%	30%	No change
KF6: Percentage of staff receiving job-relevant training, learning or development in last 12 months	76%	77%	78%	81%	+ 2%
KF5: Percentage of staff working extra hours	67%	67%	72%	72%	+ 5%

**Comparisons with data from previous surveys are not possible due to a change in survey methodology in 2012.*

The top four ranking scores are all better than the national average and in the main show improvements over 2011. However, staff suffering work related stress has increased and whilst still below the national average this will form one of the key areas for attention in 2013.

Our other priority areas for the coming year include:

- improvements in mandatory training across all staff groups
- the number of staff receiving effective appraisal interviews
- the number of staff working additional hours
- staff experiencing harassment and bullying from patients, relatives or public.

Future priorities and targets

Along with the priorities identified above, we also plan to implement a wellbeing strategy and establish a wellbeing and culture committee. This will bring together clinical and non-clinical staff from across the trust to achieve further improvements in staff engagement in coming years and to help embed the QVH values and behaviours. The work will be closely linked to our leadership and staff development programmes, ensuring we build on the effectiveness and efficiency of our teams. Additionally, the wellbeing and culture committee will be responsible for monitoring future performance in this area, providing reports to the board and to our governors.

3.5 Stakeholder relations

QVH provides services for a population of over 4 million people across Kent, Surrey and Sussex, so many individuals, communities and organisations have an interest in the organisation.

With the implementation of the Health and Social Care Act 2012, the structure of stakeholder organisations in both local government and the health service changed in April 2013.

Through 2012/13 QVH worked closely with its commissioners – firstly as primary care trusts led by NHS Sussex and then through the transition to clinical commissioning groups led by NHS Horsham and Mid Sussex CCG which will take over the lead commissioning function.

Specialist commissioning (which now covers the burns, dental and maxillofacial services at QVH) has been redesigned and now sits with the new national commissioning board, NHS England, led locally by the Area Team for Surrey and Sussex.

Clinical networks are being developed across the region and will incorporate previous groups set up for cancer, trauma, etc. While these develop, QVH continues to liaise with relevant organisations to ensure the existing programmes of work continue. Health oversight and scrutiny committees will develop into the new health and wellbeing boards which will include local government and health service representation. QVH will continue to develop strong working relationships with its stakeholders as their organisations and roles evolve.

A challenge for QVH is that it serves four counties but proportionally its services are not as significant in each local area as those of the local district general hospital. This can mean that attention to QVH issues is less than it might be. At the same time, the ability of QVH to contribute to discussions and service reviews in each area is constrained by time and geography. This places significant demands on both executive and clinical staff and carries a significant risk for the organisation of unintended consequences from decisions made about health care services when those decisions do not take QVH into account.

In order to continue to provide the hospital's tertiary specialist services that are unique in the south east, the hospital must also be able to continue providing the more common and routine procedures in each of its specialty disciplines. It is these which provide the clinical and financial sustainability that allow the complex treatment of rare and occasional problems. In this, the continued support of commissioners, GPs in the surrounding area and patients who choose to come to QVH, or to its services at other hospitals, is essential.

QVH works closely with district general and teaching hospitals across the four counties, providing tertiary support in the management of patients with complex soft tissue damage, corneal, or maxillofacial surgical needs. To ensure access to our specialist services, these relationships at both clinical and corporate levels are crucial. QVH works to ensure that it provides services which are complementary to and supportive of the services provided locally by these partner hospitals, while seeking to ensure their services are developed in a similarly complementary fashion.

The hospital continues to value highly the support and encouragement of its local population and East Grinstead Town Council. The hospital is fortunate to have a strong body of members and governors, a willing body of volunteers, and a supportive league of friends.

3.6 Estate

Over the last financial year, improvements to our estate infrastructure have continued.

The first phase of the theatres development is progressing well, and is both on plan and on budget to open in the summer of 2013.

A full business case has been approved for the second phase of the theatres development which will consolidate all ten operating theatres within a single site. Planning for construction of these additional four theatres is well advanced and scheduled to commence in the summer of 2013 with an anticipated completion date of April 2014.

Work on the replacement of the old steam boilers with a new heat exchange system is now complete.

Continued investment in the estate in recent years is now showing positive results with high-risk backlog costs reduced from £3,400,000 in 2007/8 to zero in 2012/13.

3.7 Research and development

A major focus of our activity this year has been a push to increase our involvement in national portfolio studies and we have successfully increased that number from two last year to eight this year. A new, full-time dedicated research nurse has been appointed to coordinate our portfolio studies and this extra resource will help further develop this area of our work.

Our focus on capacity building has also resulted in an increase in our non-portfolio research studies from 22 to 33. This has led to a much greater number of our patients being involved in research studies – up from 352 to 522 this year.

QVH is collaborating with a number of academic and other organisations on research including the University of Brighton, the University of Sussex, the University of the West of England, the Blond McIndoe Research Foundation and the Brighton and Sussex Medical School. We are also planning new work with the University of Surrey in the area of sleep studies. In addition, the trust has identified charitable funds to support a senior research post.

The comprehensive local research network has reviewed our work and agreed that there are substantial opportunities for research at QVH. Despite a tight financial environment it has renewed our funding contract for 2013/14.

3.8 Directors' disclosures and other disclosures in the public interest

The remaining directors' disclosures and a range of other disclosures in the public interest are provided in full in annex G.

Governance report 4

4.1 Constitution

The Health and Social Care Act 2012 (the 2012 Act) received royal assent in March 2012.

As a result, NHS foundation trusts have had to prepare associated changes to their constitutions which define how each foundation trust operates from a governance perspective.

The provisions of the 2012 Act passed into law in stages referred to as commencement orders. The majority became applicable as of 1 April 2013. But earlier commencement orders have applied.

The 2008 version of the QVH constitution was updated in line with the second and third commencement orders of the 2012 Act in October 2012, following approval by the council of governors at its meeting held on 30 October 2012. This version was submitted to Monitor for approval in January 2013 since the regulator retained powers under the NHS Act 2006 to approve amendments to foundation trust constitutions until 1 April 2013. We were notified of formal approval for these amendments to the QVH constitution from Monitor on 28 March 2013.

4.2 Council of governors

The council of governors comprises 27 governor positions:

- 20 public governors, who are elected by the foundation trust public constituency membership
- 3 staff governors, who are elected by members of the staff constituency
- 4 appointed governors.

The appointed governors represent four key stakeholder organisations:

- the QVH League of Friends,
- East Grinstead Town Council
- the local authority
- the trust's lead primary care trust (PCT).

The council of governors held four meetings in public in 2012/13 which all directors were expected to attend. Foundation trust members were invited to attend all meetings and they were advertised to the general public online and in the local newspaper.

A table setting out the members of the council throughout 2012/13 and their attendance at meetings is provided in annex E.

Membership of the council of governors

The trust welcomed Dr Howard Bloom as the appointed governor for the local authority in April 2012. As PCTs would cease to exist from 31 March 2013, no appointed governor was allocated by the trust's lead PCT to join the council.

In 2012, three public governors came to the end of their final term of office and one governor came to the end of their first term. An election was held in April 2012 for four public governor positions. Candidates were encouraged to attend pre-election events to find out more about the governor role before standing for election. Ten candidates stood for election and turnout was 22%, the highest in a number of years. One governor was re-elected for a second term and three new governors were elected. Since this election three governors were unable to continue in their role and the council has carried these vacancies through to 2013.

No election was held in the staff constituency.

Roles and responsibilities

In order for the council of governors to conduct its business efficiently it has two sub-committees: the governor steering group and the appointments committee. They allow smaller groups of governors to discuss matters in more detail and make recommendations to the full council at formal meetings.

The governor steering group, chaired by the vice-chairman of the council of governors, met monthly in 2012/13 to review the regular finance and performance reports of the board of directors and to discuss governor business. These meetings were attended regularly by the chief executive, chairman and a non-executive director in order for governors to be briefed about trust activities and to discuss any concerns they may have. The minutes from these meetings are shared with the full council of governors.

The appointments committee makes recommendations to the full council of governors regarding the remuneration and appointment of the chairman and non-executive directors, in addition to reviewing protocols, role descriptions and appraisal processes. In 2012/13, the committee focused its attention on detailed succession planning for the future replacement of the chairman and non-executive directors to ensure a smooth transition for the trust and maintain a strong and balanced board of directors.

In addition to the formal sub-committees of the council of governors, governors are invited to join or form various committees and groups across the organisation. This enables governors to see the work of the management teams and non-executive directors and also ensures the 'lay' view is considered and incorporated in management decisions where appropriate. These committees include; membership; quality and risk; audit; patient experience; theatre project steering group; and equality, diversity and human rights.

The council of governors supported public governor Brian Goode to act as governor representative to the board of directors. The governor representative attends all meetings of the board of directors in full (in a non-voting capacity). Ian Stewart continued to act as vice-chairman of the council of governors. Both meet regularly with the chairman and company secretary.

Members may contact governors and request to view the register of governors' interests by contacting the company secretary.

4.3 Board of directors

Membership and compliance

At 31 March 2013, the QVH board of directors comprises a chairman, four non-executive directors and four executive directors. There were no vacancies during the course of the year. The trust believes the board of directors to be balanced, complete, appropriate and compliant with the provisions of the NHS Foundation Trust Code of Governance and its own terms of authorisation. During the course of 2012/13, both the board and the council of governors have paid particular attention to the balance, completeness and appropriateness of the board in anticipation of changes to its composition during 2013/14.

Non-executive directors

Paragraph 9.4 of the trust's constitution sets out the process for the selection and appointment of non-executive directors (NEDs). All NED appointments are subject to the approval of the council of governors and are for an initial term of three years, which can be renewed for a further term subject to satisfactory performance appraisal. Paragraph 9.10 of the constitution sets out the circumstances that disqualify a person from becoming or continuing as a NED. In addition, should a NED not receive a satisfactory performance appraisal and prove unwilling or unable to address the issues raised, their appointment can be terminated with the approval of the council of governors.

During 2012/13, the appointments committee of the council of governors, which has responsibility for the appointment, remuneration and terms of non-executive directors, reviewed the terms of office of the chairman and non-executive directors as part of an on-going succession planning process. In October 2012, the appointments committee recommended to the council of governors that Peter Griffiths' term of office as chairman should be extended by two years to 31 March 2015. The rationale was to ensure continuity and stability of the board of directors while other changes of executive and non-executive directors took place. The appointments committee and council of governors' considerations included Peter Griffiths' independence, having served on the board for more than six years from the date of his first appointment. On balance, the council of governors considered the plan appropriate and approved it and Peter Griffiths accepted an extension to the terms of his contract.

Relationship with governors and members

The board of directors maintains close links with the council of governors through various mechanisms, including a governor representative's attendance at every board of directors meeting, directors' attendance at each council of governors meeting, and directors' attendance on a regular basis at governor steering group meetings and governor forum meetings. This allows directors and governors to freely and regularly exchange views and information on matters of importance and topical interest. Governors represent members' views to directors, to ensure these are taken into account in terms of forward planning.

Interests

A register of directors' interests is kept by the trust and is available on request to the company secretary.

Meetings

All meetings of the board of directors in 2012/13 were held in private and attended by the governor representative, programme director, head of human resources and organisational development, and company secretary.

Evaluation

The NHS Foundation Trust Code of Governance sets out an expectation that all NHS foundation trusts will "undertake a formal and rigorous annual evaluation of its own performance".

At QVH, this process was most recently initiated by the chairman in January 2012. The chairman met with each executive and non-executive member of the board, the head of human resources and organisational development and the governor representative between February and April 2012 in order to receive personal feedback and opinion on the effectiveness of the board. The meetings were attended by the company secretary who wrote a summary report on the discussions.

In preparation for the meetings, board members and attendees were sent the specimen self-appraisal questionnaire provided by the Foundation Trust Network in its compendium of governance best practice published in October 2011. Each meeting was broadly structured around the questionnaire but included an invitation to comment on any aspect of the board's effectiveness.

Key themes were identified and an action plan was discussed and agreed by the board in June 2012.

Both executive and non-executive directors are also subject to individual annual performance appraisal.

Sub-committees

There are four formal sub-committees of the board:

- Audit committee
- Charitable funds advisory committee
- Nomination and remuneration committee
- Quality and risk committee.

The audit committee and nomination and remuneration committee comprise only non-executive directors. The quality and risk committee and charitable funds advisory committee comprise both executive and non-executive directors.

A table setting out the members of the board throughout 2012/13 and their membership of, role in and attendance of each of the four sub-committees is provided in annex D.

4.4 Audit committee

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

Membership and attendance

Provision F3.1 of the NHS Foundation Trust Code of Governance recommends that the audit committee comprises three non-executive directors. However, given the size of the trust, the QVH audit committee comprises two independent non-executive directors. This is to ensure a balance of non-executive director representation across board committees.

The audit committee is chaired by non-executive director Shena Winning who is a chartered accountant with over 20 years' experience within the retail sector.

Full details of the membership and attendance of audit committee meetings held during 2012/13 is provided in annex D.

How the committee discharges its responsibilities

During the year, the committee received reports from the trust's internal and external auditors that provided the committee with a review of the trust's internal controls and risk management systems. The scope of internal audit coverage extended beyond financial systems and controls and for 2012/13 included work on operational efficiency in theatres and outpatients, a review of the Choose and Book system as well as work on information governance. The internal auditors were able to report full or significant assurance for 95% of the areas reviewed, resulting in a head of internal audit opinion of 'significant' assurance.

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

In performing any work outside their statutory role, the external auditors took all necessary steps to ensure they maintained their independence from the trust.

Counter fraud

In 2012/13, Chantrey Vellacott acted as providers of the trust's local counter fraud specialist (LCFS) service. An annual work plan was agreed with the LCFS and delivery was overseen by the audit committee. Our counter fraud policies and procedures are widely publicised and covered at induction for new staff.

4.5 Charitable funds advisory committee

The charitable funds advisory committee (CFAC) meets quarterly to oversee the management, investment and disbursement of the Queen Victoria Hospital NHS Foundation Trust Charitable Fund within the regulations provided by the Charities Commission and to ensure statutory compliance. It manages the income and expenditure of a suite of general funds and supervises the expenditure and income of a suite of directorate funds. It makes recommendations to and acts on behalf of the board of directors as corporate trustee of the charitable funds.

Membership

In 2012/13, the CFAC was chaired by Renny Leach, non-executive director and senior independent director. Other members include non-executive directors Shena Winning and Lester Porter, the director of finance and commerce, the medical director and the company secretary. One public and one staff representative of the council of governors attend meetings and provide comments on behalf of the council.

Full details of the membership and attendance of the CFAC meetings held during 2012/13 is provided in annex D.

4.6 Nomination and remuneration committee

The nomination and remuneration committee usually meets four times each year to review and make recommendations to the board of directors on the composition, balance, skill mix and succession planning of the board. Additionally, the committee makes recommendations on the appointment of executive directors and is responsible for setting the overall strategy for the remuneration of all trust staff.

The committee has particular emphasis on the remuneration packages and contractual terms for the chief executive, the executive directors and other senior managers reporting directly to the chief executive.

Membership

In 2012, Peter Griffiths, the trust chairman, chaired the committee which comprises the chief executive and all non-executive directors. The committee receives secretariat support and professional advice from the head of human resources and organisational development. Additional advice and support is provided by the company secretary.

Full details of the membership and attendance of the nomination and remuneration committee meetings held during 2013/13 are provided in annex D.

Activities in 2012/13

During the year the committee determined and pursued its agreed work programme and made decisions or recommendations on the following areas:

- national pay awards
- board effectiveness review
- recruitment of a chairman and chief executive
- performance of the chief executive and his direct reports
- salary benchmarking
- NHS pensions developments
- committee terms of reference
- 2013/14 work plan.

The trust's remuneration strategy aims to set levels of pay which help to attract and retain skilled and talented staff throughout the organisation. The committee therefore takes account of current NHS practice as well as considering wider commercial practice. The majority of staff in the trust are covered by the national Agenda for Change terms and conditions. The chief executive, executive directors and other very senior managers are covered by local senior managers' terms and conditions whilst doctors are subject to national medical and dental terms and conditions.

Pay and terms for executive directors remained unchanged during 2012/13. In line with the requirements of the NHS Foundation Trust Code of Governance, executive directors' performance was reviewed against trust and individual objectives through an established appraisal system.

Contractual arrangements for the executive team are permanent and include three month notice periods. The exception to this is the chief executive who is required to give six months' notice. There are no specific clauses regarding compensation and early termination.

The council of governors, on the recommendation of the appointments committee, determines the remuneration and appointment of the trust's chairman and non-executive directors. Public governor Valerie King is chairman of the appointments committee which comprises a range of public, staff and appointed governors, advised by the company secretary and, where appropriate, the chairman.

The salary details of the trust's chairman, executive and non-executive directors are set out in annex C. There have been no compensatory agreements during 2012/13.

4.7 Quality and risk committee

The quality and risk committee is a well-established sub-committee of the board that is chaired by a non-executive director. The committee meets quarterly and reviews information on risk management and compliance from across the organisation. The committee's role is to assure the board of directors that there are sound and effective systems and processes in place, with operational delegation of risk to sub-committees and directorates. The committee reviews compliance with infection prevention and control standards and Care Quality Commission outcomes. It also monitors delivery against the quality account priorities and CQUINs. The committee monitors the board assurance framework which is populated with the risks associated with the delivery of the trust's key strategic objectives. This is provided to both the audit committee and the board of directors.

Membership

Jeremy Beech, non-executive director, is chair of the quality and risk committee and is supported by his non-executive colleague Lester Porter. Membership includes all executive directors and other members of the senior management team and staff from across the organisation. A representative of the council of governors attends meetings and provides comments on behalf of the council.

Full details of the membership and attendance of the quality and risk committee meetings held during 2012/13 is provided in annex D.

4.8 Foundation trust membership

The trust has two constituencies of foundation trust membership: public and staff.

Public membership is open to anyone over the age of 18 who lives within the borders of Kent, Surrey, East Sussex and West Sussex. Affiliate membership is available for those aged between 16 and 18 years of age or who live outside of the four counties served by the trust. Full members are eligible to vote in annual elections for public governor positions.

On 31 March 2013, there were 9,067 full public members and 361 affiliate members.

All staff with a permanent contract of employment become staff members but may choose to opt out. Staff members are eligible to vote in annual elections for staff governor positions.

On 31 March 2013, there were 933 staff members.

Strategy

In managing its membership base, QVH ensures that it operates in compliance with relevant legislative, regulatory and constitutional provisions at all times.

In addition, the trust aims to engage with its membership base in ways which are consistent with relevant best practice, as described in publications applicable to membership-based organisations in general and the NHS foundation trust sector in particular.

Beyond the contextual provisions and principles described above, the trust has three strategic aims with regard to membership:

- To **engage** with existing members in ways which are meaningful and interactive.
- To **promote** the benefits of membership to all QVH patients and to recruit new members who are representative of the communities the trust serves.
- To **encourage** as many existing and prospective members as possible to provide their email address and give permission for the trust and the council of governors to communicate with them electronically.

The trust is developing a full membership strategy document which aims to articulate the broad context to foundation trust membership and update the specific strategic aims of membership for QVH. It puts forward a proposal to establish annual membership action plans and suggests an action plan for 2013/14.

Disclosures and contact details

A public register of members is available for viewing by contacting the company secretary. Members should also contact the company secretary to communicate with governors and directors.

Quality accounts 5

Part 1: Statement on quality

Chief executive's statement

At Queen Victoria Hospital NHS Foundation Trust (QVH) we continue to focus on the quality of care that we provide to our patients.

Patient surveys continue to give us ratings for quality that are among the highest in the country, with results from the latest national NHS inpatient survey showing that QVH achieved the highest score out of all 156 acute hospital trusts in England for how well patients rated their experience of being in hospital. And in the latest national NHS staff survey, QVH scored the best results nationally for staff recommendation of their trust as a place to work or receive treatment, and job satisfaction.

In an unannounced two-day inspection in February 2013, the Care Quality Commission rated us highly for the compassion and care that we give to our patients, and were satisfied that we were compliant with the five outcomes they assessed. However, they raised a minor concern regarding documentation to which we will respond with action to improve the completeness of information available.

These quality accounts summarise the performance of the hospital across a range of issues in 2012/13. The report sets out our key priorities for 2013/14 which we believe will further improve our patients' care and hospital experience.

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

Amanda Parker
Director of Nursing and Quality
28 May 2013

At the time of preparing the 2012/13 quality accounts, the position of chief executive was vacant, pending appointment from 1 July 2013. As part of the trust's interim leadership arrangements, the board of directors agreed that its Director of Nursing and Quality, Amanda Parker, would sign the chief executive's statement for the purpose of these accounts.

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

Performance against 2012/13 priorities

Priorities for 2012/13 were influenced by the trust's governors, the programme board (which includes representation from NHS West Sussex), a local GP representative, representatives from commissioners in Kent and Surrey, and staff from across the organisation.

In addition, information was considered from national reports, QVH results from national inpatient and outpatient surveys, in-house patient experience reviews, clinical incident reporting, complaints, patient safety reviews and clinical audit.

Four priorities were identified covering patient experience, the effectiveness of their medical care, and patient safety. Progress against these priorities has been monitored over the year and regular reports have been provided to staff, the trust's quality and risk committee, and the board of directors. The following is a summary of the progress we have made against each priority.

Priority 1

We aim to reduce the preoperative length of stay for elective patients.

With advances in day surgery, the types of anaesthetics available and pre-assessment, it is increasingly possible to reduce preoperative stay to minimal levels for patients undergoing elective (i.e. planned, non-emergency) surgery, unless a longer stay is justified for medical reasons. It is recognised that coming into hospital for longer than necessary can cause stress and frustration for patients who would prefer to be at home rather than in hospital. In addition, a reduction in preoperative stay would also reduce pressure on the availability of beds required during the day. Accordingly, our goal for 2012/13 was to reduce the percentage of patients admitted one or more days before surgery from 10% to 5%, by ensuring that patients undergoing elective procedures were only admitted early for medical reasons.

In order to achieve the targeted reduction there was a combined approach between nursing and medical staff around several activities, including reviewing the underlying reasons for patients being admitted before the day of surgery and changing the pathway to make it possible for them to come in on the same day.

We audited our progress monthly against a baseline figure for December 2011 by:

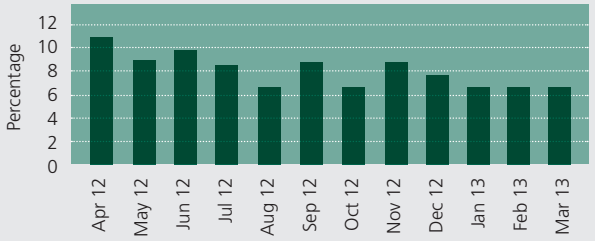
- analysing the number of patients admitted more than a day before surgery
- auditing the reasons why patients were admitted one day or more before surgery
- assuring ourselves through discharge questionnaires that shorter admission times were not having a negative effect on patient experience.

Reports on progress have been made monthly to the management team and quarterly to our quality and risk committee. They show that during the last quarter of 2012/13 we achieved a consistent rate of 6% of patients admitted before the day of surgery.

Reviewing the cases of patients admitted one or more days before surgery has shown that in the main these were patients undergoing major surgery, requiring longer preoperative preparation. Since the number of major cases is likely to remain consistent, we are of the view that 6% is the most realistically achievable target going forward. When benchmarked across other organisations, our results reflect good practice with others achieving in the region of 10-20% of elective patients admitted one or more days prior to surgery.

This will not be continued as a quality account priority for next year, though we will maintain focus on admitting the majority of patients on the day of surgery and will continue to monitor progress at operational meetings.

Percentage of elective patients admitted prior to surgery 2012/13



Priority 2

We aim to improve the outpatient experience of all patients.

QVH prides itself on providing a good patient experience. While this is generally true, we know that patient experience can still be variable at times and the national outpatient surveys, supplemented by the hospital's own patient surveys, have highlighted that improving problem scores in a number of areas could significantly improve the experience of our patients. We therefore set our goal to reduce our national survey problem scores by 10%.

We have achieved this goal in some but not all areas of the patient experience that we had identified.

The actions we took during 2012/13 to improve the experience for patients have included:

- **Opening a new main outpatients department in April 2012.** This has reduced the number of outpatient departments, making it easier for patients to know where to go. It has created a better waiting area and centralised the reception areas.
- **Reviewing 'standard' outpatient department clinic letters and reducing them from 300 to 10.** This has improved the standard of the letters to patients, making them easier to understand and easier for patients to identify where in the hospital they should attend.
- **Agreeing a standardised booking process for all departments.** Patients attending multiple clinics now experience a clearer, more consistent booking process.
- **Merging the speciality booking teams into one to support the above.** This has further standardised the approach for patients. In addition, opening hours have been extended to allow patients to make booking appointments more convenient.
- **Introducing patient self check-in systems.** Self check-in means that patients do not have to queue at a reception desk. The system informs patients if there is a delay to their clinic, so that they are kept well informed.
- **Introducing media screens and patient calling systems in main waiting areas.** Media screens provide a form of distraction for waiting patients, as well as a patient calling service, updates on any clinic delays, and a health information resource.
- **Developing posters and leaflets to inform patients of the common reasons why clinics run late.** Posters and leaflets displayed in waiting areas help patients to understand why delays may occur, and why at times they are unavoidable. The information also includes, for example, how patients can get refreshments without worrying about missing their appointment.
- **Responding to patients' comments by reviewing hand and corneoplastic clinic templates and patient flow.** Work has commenced on the review of clinic templates (schedules), to ensure that multiple patients are not being called for the same appointment time, thereby removing built-in delays and reducing the time patients wait to be seen. This will also reduce the number of cancellations made by QVH, as revised templates will be adjusted to allow for emergency appointment slots.
- **Implementing digital dictation.** This has resulted in patients receiving more timely feedback in letter form following clinic appointments.

- **Introducing monthly patient satisfaction surveys.** Surveys have been used to capture and understand patients' views of their experience throughout the year. Feedback has been variable, and returns in Q4 reduced significantly, possibly due to returning patients feeling that they had already participated. During March significant effort was made to gain feedback from the three main clinic areas. Our aim was to improve on our national patient survey problem scores by 10% in four areas (see below).

Our four problem scores were:

1 **Other patients could overhear discussions with receptionists.** Our score at the end of the year was 29% with scores ranging from 66-29% throughout the year. This has exceeded our target of a 10% reduction against our previous score of 72%. However, during 2013/14 we shall look to identify improvements to waiting areas to maintain and enhance patient privacy.

2 **Patient not told why they had to wait.** Our score at the end of the year was 49%, and while this achieved the 10% reduction we were aiming for against a previous score of 62%, this was not achieved consistently throughout the year. Our self check-in system providing information on clinic delays was activated during 2013 and this would explain the achievement of the target at the end of the year. However, we recognise that further action is required to ensure that patients understand why they are waiting, and this should remain a focus for next year.

3 **Patient waited longer than they were told, or were not told how long the wait would be.** Our score at the end of the year was 50%. While this achieved the 10% reduction we were aiming for, against a previous score of 61% in 2011, this target was not achieved consistently throughout the year. Again, the implementation of the new check-in system during the year would explain the achievement of the target at the end of the year. We recognise that we need to take further action to inform patients about how long they may have to wait and to address the reasons for clinic delays.

4 **Nobody apologised for the delay when waiting to be seen.** Our score at the end of the year was 46%. It is disappointing that throughout the year we have not demonstrated improvement against our previous score of 40% in 2011 or against the national average of 47%. While we have been proactive in communicating with patients, this is not reflected in the survey scores and we will therefore be examining the approach we take when communicating with patients.

During 2013/14 we will be retaining outpatient experience as a priority in an endeavour to further improve our service to patients. In addition, we have chosen to expand collection of information around the NHS friends and family test question to include our outpatient areas and to measure the proportion of patients who would recommend the hospital to family and friends.

Priority 3

We aim to take patient consent for elective surgery prior to the day of surgery at QVH.

Before patients can give informed consent to treatment they need comprehensible information about their condition and about possible treatments and investigations, including the associated risks and benefits of surgery or other alternatives. They need time in which to consider this information, and possibly discuss it with members of their family.

Patients should be able to consent to surgery before the day of their surgery, and then be able to confirm that consent on the day.

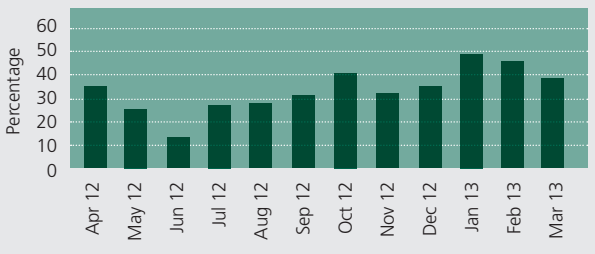
We recognise that we could improve our current processes to benefit patients by providing them with earlier information and obtaining consent to surgery before their hospital admission.

Our ultimate aim is for 75% of patients undergoing elective surgery at QVH to have their consent completed prior to the day of surgery, and our goal for 2012/13 was to achieve 50%. Significant strides have been made towards achieving this target (see table below) and this will remain a focus for the organisation in 2013/14.

During the year we have amended processes in an attempt to remove any barriers to consent being taken before the day of surgery. One challenge has been the issue of patients seen at off-site clinics. This has been addressed by ensuring that consent forms are available at our off-site clinics.

Some progress has been achieved during the latter half of the year, with some months approaching the target of 50%. This will remain a priority for 2013/14 as planned during 2012/13.

Patient consent prior to day of surgery



Priority 4

We aim to provide health care professionals with dementia awareness training in order to complete dementia screening and dementia risk assessment of patients.

The Department of Health is committed to improving care for dementia and ensuring early diagnosis. The report of the National Audit of Dementia Care in General Hospitals 2011 provided clear recommendations including the provision of awareness training for all staff, and more in-depth training for core staff.

Our target was to deliver dementia awareness training to more than 75% of our qualified nursing staff, allied health care professionals and medical staff, to support the roll out of dementia screening and risk assessment as required by the national Commissioning for Quality and Innovation (CQUIN) goals for 2012/13. We achieved this target, training 80% of clinical staff during 2012/13.

Our plan for 2013/14 is to continue this roll out to non-clinical staff and consider what other actions we can take to improve awareness amongst hospital staff. This will not be a quality account measure for 2013/14 but will be monitored through our dementia CQUIN measures.

Priorities for 2013/14

Priorities for 2013/14 have been influenced by the trust's governors, the programme board (which includes representation from NHS West Sussex), our lead clinical commissioning group, and staff from across the organisation

In addition, information was considered from national reports, QVH results from national inpatient and cancer surveys, in-house patient experience reviews, clinical incident reporting, complaints, patient safety reviews and clinical audit.

Four priorities were identified, covering patients' experience, the effectiveness of their medical care, and patient safety. Having monitored last year's objectives, we have determined that two of these should remain as priorities for the coming year. These are:

- improving the experience of people attending our outpatient departments
- continuing with the longer-term objective to take consent for surgery within the outpatient department for 75% of patients undergoing elective surgery.

The four priorities proposed for QVH for 2013/14 are:

Priority 1

We aim to improve the outpatient experience of all patients.

QVH prides itself on providing a good patient experience. While this is generally true, we know that patient experience can be variable at times, and the national outpatient surveys, supplemented by the hospital's own patient surveys, have highlighted that improving problem scores in a number of areas could significantly improve the experience of our patients.

A number of actions were taken during 2012/13. However, these did not impact on the key issue for patients - waiting times and issues around these. Survey methodology used during the year was also acknowledged to be repetitive and different options for information collection have been considered for 2013/14. Results will also be supplemented by a national outpatient survey during the coming year.

Our objective is to measure patients' experience in line with the NHS friends and family test question and to collect information on the time patients wait. This will be the time from when their appointment was due to when they were actually seen, and will be collected from the electronic booking system introduced during 2012/13.

Activities have been planned to support an improved experience for outpatients in 2013/14, including:

- detailed assessment of demand and capacity leading to possible changes to the time allocated to clinic appointments
- reviews of clinics which experience regular delays to explore how the clinic is managed and identify areas for improvement
- introduction of a daily named nurse in charge of the outpatient department
- nurse and therapy led clinics
- an alert system to address the issues in clinics that are delayed
- introduction of a mechanism to ensure that clinic utilisation is maximised, in the same way as we do for our operating theatres (i.e. three weeks ahead)
- extended use of the self check-in and patient calling system.

We will evaluate our progress during the year by measuring:

- clinic start and finish times
- percentage utilisation of clinics
- overall time patients spend in clinic from check-in to leaving
- number of appointments cancelled by the hospital
- DNA (did not attend) rates
- patient satisfaction via the NHS friends and family test question and national outpatient survey.

Reports on progress will be made monthly to the management team and quarterly to our quality and risk committee and our board of directors and council of governors.

Priority 2

We aim to take patient consent for elective surgery prior to the day of surgery at QVH.

Before patients can give informed consent to treatment they need comprehensible information about their condition and about possible treatments and investigations, including the associated risks and benefits (which include the risks/benefits of doing nothing), and alternatives. They need time in which to consider this information, and possibly discuss it with members of their family.

Patients should be able to consent to surgery before the day of their surgery, and then be able to confirm that consent on the day.

We recognise that we could improve our current processes to benefit patients by providing them with earlier information and obtaining consent to surgery before their hospital admission.

Our aim is for 75% of patients undergoing elective surgery at QVH to have their consent completed prior to the day of surgery. Our goal for 2013/14 is to achieve 75%, having achieved a maximum of 48% against a target of 50% during 2012/13.

Reports on progress will be made monthly to the management team and quarterly to our quality and risk committee and our board of directors and council of governors.

Priority 3

We aim to improve the completeness of data required as part of the Cancer Outcomes and Services Dataset (COSD) for the Thames Cancer Registry.

The Cancer Outcomes and Services Dataset (COSD) is the new national standard for reporting cancer in the NHS in England. Introduced in January 2013, it replaces the National Cancer Dataset which has been revised in order to meet the current information requirements for the NHS. The Cancer Reform Strategy (2007) identified better information and stronger commissioning as two of the key drivers to achieve the goal that cancer services in this country should be amongst the best in the world.

In the UK we are in a unique position to gather whole population outcomes and services data because cancer treatment is usually carried out within the NHS, providing the opportunity for data to be collected in a standardised and measurable form so that it is consistent and meaningful. These data collection improvements should lead ultimately to improvements in cancer services and treatment for patients, the highlighting of conditions associated with geographical areas and family links, and to a better understanding of cancer recurrence so that care and treatment can be planned effectively.

The COSD clarifies the items that need to be submitted electronically directly to the cancer registries on a monthly basis. Many trusts are already sending data directly to the registries from a range of systems, but the aim of the COSD is to collate these into one overarching system.

As the dataset is comprehensive and requires significantly more information than previously, it is being implemented in phases. The initial phase concentrates on items which are mandatory for all cases diagnosed from 1 January 2013. This is followed by two further phases culminating in a complete dataset being regularly submitted every month by January 2015.

During the course of its implementation, the Thames Cancer Registry will provide quarterly updates on progress with data completeness for each trust. We aim to be at least 75% compliant for phase 1 by Q2 2013 by developing IT processes to automate the data collection from a number of sources, using both Infoflex and Somerset databases. We also aim for our data to be above 85% complete for both phases 2 and 3 by the end of the year.

Reports on progress will be made quarterly to the management team and to our quality and risk committee and our board of directors and council of governors.

Priority 4

We aim to produce quality assurance information on an individual consultant basis.

QVH is proud of its achievements in delivering safe, effective care to patients, combined with a good patient experience. However, we are aware that the publication of the report by Sir Robert Francis on the care provided at Mid Staffordshire Hospital has left patients, commissioners and healthcare providers concerned about how they can be confident of the quality of care patients receive in a hospital.

We recognise that the information that might assure each of these different groups may not necessarily be the same. As a first step to providing information that would assure all groups, we intend to develop and use currently available information at individual consultant level on patient safety, effectiveness of care and patient experience.

The information will initially be provided to consultants so that they can be confident of data sources and use it to monitor and develop their practice. As an organisation we are conscious of ensuring that data made available to the public is accurate, meaningful and can be easily understood in order to provide them with the information they need to make informed choices. Therefore we will ask our auditors to review the information we intend to make available to confirm its accuracy.

During the year we intend to review what information on consultants' results and outcomes we would like to provide to the public and commissioners. We will be guided in this by national recommendations, adopting them where they apply to our specialties and, where not directly relevant to our services, still aiming to adopt the principles behind them where possible. We will then need to identify the information systems available or invest in those required to support collection of the required information.

By the end of June 2013 we will identify the information we have available with current resources. From September 2013 we will begin providing consultants with their information. Progress will be built on over the year and reported through the clinical outcomes group, our quality and risk committee, our management team, the clinical cabinet and the board of directors.

Statements of assurance from the trust board

Review of services

During 2012/13 QVH provided burns care, general plastic surgery, head and neck surgery, maxillofacial surgery and corneoplastic surgery and community and rehabilitation services. QVH has reviewed all the data available to them on the quality of care in all of these NHS services.

The income generated by the relevant health services reviewed in 2012/13 represents 100% of the total income generated from the provision of relevant health services by QVH for 2012/13.

Review of quality of care

QVH continues to have systems and processes in place through quarterly directorate reviews conducted by the chief executive to assure itself regularly on the quality of service provided to patients. At these meetings, the safety of care is monitored through governance reports on incidents, infection control and identified risks. Where there are concerns, action plans are put in place and reviewed at monthly operational meetings of the directorates. Clinical effectiveness is reviewed through reports on cancelled operations, clinical indicators, clinical outcome measures, waiting times for surgery, and patient complaints. Patient experience is reviewed through complaints and feedback questionnaires. A summary quality dashboard is presented monthly to the clinical cabinet and board of directors of the organisation. the audit committee routinely reviews the framework of control in respect of quality and reports regularly to the board of directors.

Where the executive team or a directorate identifies a significant concern they will instigate actions that are documented and regularly reviewed. Significant incidents are reported through to the trust board and followed up through the quality and risk committee. All executive directors have been involved in the drafting of the quality account and believe the contents to be a true and accurate reflection of the quality of care provided by QVH.

Participation in clinical audits

During 2012/13, four national clinical audits and four national confidential enquiries covered relevant health services that QVH provides.

During 2012/13, QVH participated in 50% of the specified national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to take part in.

The national clinical audits and national confidential enquiries that QVH was eligible to participate in during 2012/13 are as follows:

National clinical audits	Participation
Head and neck oncology (DAHNO)	✓
Audit of Blood Sample Collection and Labelling (National Comparative Audit of Blood Transfusion)	✓
National Cardiac Arrest Audit (NCAA)	✗
Adult critical care (ICNARC CMP)	✗

National confidential enquiries	Participation
Subarachnoid haemorrhage (NCEPOD)	✓
Alcohol related liver disease (NCEPOD)	✓
Bariatric surgery (NCEPOD)	✓
Cardiac arrest procedures (NCEPOD)	✓

We do not participate in the National Cardiac Arrest Audit as our number of cardiac arrests treated with cardiopulmonary resuscitation is very low (usually less than five per year). All cardiac arrests are audited locally, and we took part in the recent NCEPOD cardiac arrest procedures study.

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

Although the National Parkinson's Disease Audit covered NHS services that QVH provides, we were unable to participate because the number of coded cases identified was below the minimum required by this study.

Four other national enquiries monitor mortalities from a range of causes. These are maternal, infant and perinatal (MBRRACE), child health (CHR-UK), suicide and homicide in mental health (NCISH) and asthma deaths (NRAD). We are aware of these studies and we routinely review all of our small number of in-hospital deaths with a view to participation if appropriate. To date we have not had any relevant cases to report.

The national clinical audits and national confidential enquiries that QVH participated in, and for which data collection was completed during 2012/13, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the term of that audit or enquiry.

National audits / confidential enquiries	% cases submitted
Head and neck cancer (DAHNO)	100% coded cases between November 2011 and September 2012
Audit of Blood Sample Collection and Labelling (National Comparative Audit of Blood Transfusion)	Cases submitted on behalf of QVH by Brighton and Sussex Pathology
Subarachnoid haemorrhage (NCEPOD)	100% coded cases
Alcohol related liver disease (NCEPOD)	No relevant cases, but organisational data submitted
Bariatric surgery (NCEPOD)	Bariatric surgery is not carried out at QVH, but organisational data submitted
Cardiac arrest procedures (NCEPOD)	100% cases

Other national audits we have participated in during 2012/13 include:

- National NHS inpatient survey
- National Safety Thermometer
- International Burn Injury Database (IBID), incorporating the UK National Burn Injury Database (NBID)
- National Anaesthetic Audit (accidental awareness during general anaesthesia in the UK): NAP5

The reports of 16 national clinical audits were reviewed by the provider in 2012/13 and QVH intends to take the following actions to improve the quality of healthcare provided:

- coordinate a response to a number of national patient and staff surveys via the trust's patient experience group and Macmillan team, and to monitor actions taken
- re-audit the findings of a number of national occupational health-related audits to ensure that recommendations have been actioned
- develop a new system for the review of cardiac arrest cases, allowing for more timely and detailed analysis
- consider the appointment of anaesthetics DNAR (do not attempt resuscitation) specialist advisors
- continue progress towards implementation of a single, flexible and robust database for collection of head and neck data

- identify QVH head and neck-specific outcome measures
- ensure presentation of findings of relevant national audits and confidential enquiries to a trust-wide audience to increase awareness.

The reports of 139 local clinical audits were reviewed by the provider in 2012/13 and QVH intends to take the following actions to improve the quality of healthcare provided:

- further develop the methodology of a project identifying post-operative venous thromboembolism (VTE) cases from multiple sources
- following implementation of a specific consent form for head and neck patients, to consider the development of additional procedure-specific consent forms
- carry out an audit linked to advanced recovery pathways for breast reconstruction patients
- consider use of national patient reported outcome measure questionnaires to monitor outcomes in breast reconstruction patients
- following the development of guidelines for plastic surgery, to develop specialty-specific surgical antimicrobial prophylaxis guidelines for maxillofacial and corneoplastics departments with input from departmental leads
- extend a programme of rolling documentation audit, based on the successful piloting of a new data collection tool conducted earlier in the year.

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by QVH in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 522.

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

QVH was involved in conducting 39 clinical research studies in 2012/13, involving clinical staff in four medical specialties as well as professions allied to medicine.

Use of the Commissioning for Quality and Innovation payment framework

A proportion of QVH income in 2012/13 was conditional on achieving quality improvement and innovation goals agreed between QVH and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further detail of the agreed goals for 2012/13 and for the following 12 month period are available online at www.monitor-nhsft.gov/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

The monetary value attached to achieving CQUINs for 2012/13 was £1,249,440. Activity to achieve CQUINs was undertaken and regularly reported on. A total of £864,192 associated payment was made for CQUINS in 2011/12. This was a 100% achievement of our CQUINs for 2011/12.

Care Quality Commission registration and periodic and special reviews

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

CQC has not taken enforcement action against QVH during 2012/13.

QVH has participated in a routine inspection by CQC relating to the following areas during 2012/13:

Outcome 2: Consent to care and treatment

Outcome 4: Care and welfare of people who use services

Outcome 7: Safeguarding people who use services from abuse

Outcome 12: Requirements relating to workers

Outcome 16: Assessing and monitoring the quality of service provision

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential.

QVH intends to take the following action to address the conclusions reported by CQC:

- feedback to the organisation on the Outcome 21 failings in the inspection report
- feedback results of the annual documentation audit to medical staff and other staff at joint hospital audit meeting
- deliver a record-keeping standards education session across all clinical areas.
- conduct three-monthly patient health record audits that result in action plans, with ownership where non-compliance is noted
- conduct compliance in practice audits of all areas, commencing with those identified within the CQC report
- revise out of date local rules for radiology department, and publish and communicate these

- ensure that records pertaining to Radiation Protection Supervisors (RPS) and operators' qualifications and training are documented and accessible
- develop processes that allow an integrated patient health record.

QVH has made the following progress by 31 March 2013:

- feedback to the organisation on Outcome 21 failings has occurred
- feedback on the annual documentation audit via the joint hospital audit meeting has been completed.

Other actions remain in progress.

Data quality

QVH submitted records during 2012/13 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS number was:
  - 99.6% for admitted patient care
  - 99.7% for outpatient care
  - 97.7% for accident and emergency care.
- which included the patient's valid General Medical Practice Code was:
  - 100% for admitted patient care
  - 100% for outpatient care
  - 100% for accident and emergency care.

QVH's overall information governance assessment report overall score for 2012/13 was 77% and was graded green.

QVH was not subject to the payment by results clinical coding audit during the reporting period by the Audit Commission.

Part 3: Review of quality performance 2012/13

QVH has well-embedded processes for ensuring that patient safety, clinical effectiveness and patient experience is reported on in respect of all of its services. Progress against our key quality indicators and those mandated are shown below. Information on the delivery of operational performance targets, feedback from patients, patient complaints and national surveys has contributed to the identification of our additional priorities for 2013/14. Within the patient safety, effectiveness and experience sections, mandated data (marked '*') is included along with the rationale and actions being taken to improve scores.

Patient safety

We are committed to patient safety and preventing harm to patients. This is identified as a key objective for the organisation and is supported by our risk strategy. We consistently look at the care we deliver with the aim of reducing harm to patients. Our approach is to continually develop and improve clinical leadership, communication and learning to create an environment of trust between patients and staff that ensures that safe, high quality, effective care is delivered to all our patients.

Our incidents, including all deaths and complications, are investigated and discussed at regular clinical directorate meetings and, where appropriate, at bimonthly joint hospital clinical audit meetings. Learning points and actions from these meetings are disseminated through the directorates, clinical policy and quality and risk committees, clinical cabinet, and the board of directors.

Within this year's safety metrics we are pleased to report that we have significantly improved our physiological monitoring of patients during admission, and correct information was recorded 96% of the time, improving on the previous year's 80%. Theatre lists commencing with a safety briefing improved to 93% from the previous year's figure of 86%, along with improved compliance with the use of the WHO Safety Checklist.

We were disappointed in our staff 'flu vaccine uptake this year and have plans in place to ensure that more mobile clinics are available to encourage staff uptake next year.

One area of care taken very seriously is hospital acquired infection. This year, while we have had no cases of Clostridium difficile, we have had two cases of MRSA bacteraemia. As a trust that specialises in managing patients with burn injuries (which both of these patients were), we recognise that those with significant burns are particularly vulnerable to acquiring MRSA bacteraemia. In both instances the patients recovered. Actions taken to prevent recurrence have included education of staff on the taking of blood cultures, a uniform review within our burns unit and an enhanced cleaning programme.

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

Patient safety indicator and why we measure it	How the data is collected	Our target	Benchmark	2010/11 result	2011/12 result	2012/13 result
Clinical incidents reported per 1000 patient spells (spell = outpatient visit or inpatient stay)	Monthly analysis of Datix clinical incident reporting system	N/A	58 per 1000 specialist acute trusts NRLS benchmark (April to Sept 2012)	51 per 1000 patient spells	44 per 1000 patient spells	43 per 1000 patient spells G
Comment: We actively encourage staff to report all incidents that have, or have potential to have, an effect on patient safety. We operate an open reporting system to aid learning from incidents. Our incident rate has remained similar to last year though is not as high as other trusts'. Our rate dropped from 2010/11 when we closed our community ward. We therefore believe our reporting rate has remained consistent. We will continue to raise awareness of the importance of reporting to staff.						
***Number of clinical incidents reported that have caused patient harm (actual number)**	Monthly analysis of Datix clinical incident reporting system Rate of patient safety incidents reported	0	32% of all incidents reported (NRLS of specialist trusts (April to Sept 2012)	187 incidents causing harm 22% of all reported incidents	124 incidents causing harm 17% of all reported incidents 7 causing moderate harm; 0 causing major harm or death	118 incidents causing harm 16% of all reported incidents 3 causing moderate harm; 0 major harm or death G
Comment: QVH intends to take the following actions to improve this 16% score and so the quality of its services by raising awareness through the mandatory training programme of the harm caused to patients from various incidents. The National Patient Safety Agency (NPSA) describe harm as: • Moderate harm – any unexpected or unintended incident which resulted in further treatment, possible surgical intervention, cancelling of treatment or transfer to another area and which caused short term harm, to one or more persons. • Severe harm (major) – any unexpected or unintended incident which caused permanent or long term harm, to one or more persons. Although we would like to see a large number of clinical incidents reported to aid governance, we would like a low number of incidents that have caused patient harm and are pleased to have seen less harm a result of incidents during 2012/13. All incidents that have caused harm or had the potential to cause harm are thoroughly investigated and findings are reported to the quality and risk committee.						
Documented consultant review of emergency admissions within 24 hours	Internal six monthly retrospective audit of 50 trauma patients	100%	92% (NCEPOD)	82%	72%	75% G
Comment: NCEPOD recommends that all emergency admissions are reviewed by a consultant within 24 hours of admission and that this is documented clearly. We report back our findings to our consultants to raise awareness. In some cases, due to our ability to manage the patient's surgery efficiently, some patients who may have had a more minor injury requiring surgery at QVH may have been admitted, undergone surgery and been discharged within 24 hours, so may not have seen a consultant during that time.						
Hand hygiene (washing or alcohol gel use)	Internal monthly audit of the five moments of hand hygiene	100%	N/A	93%	97%	98% G
Comment: Good hand hygiene is linked with a reduction in hospital acquired infections. This measure has shown a consistent improvement over time. To ensure standards remain high, monthly audits are undertaken in all clinical areas and any staff member noted not to be complying is challenged and reminded why compliance is required.						

Patient safety indicator and why we measure it	How the data is collected	Our target	Benchmark	2010/11 result	2011/12 result	2012/13 result
***VTE risk assessment (percent of admissions)** Patients assessed for the risk of venous-thromboembolism can have the correct precautions, including compression stockings and low molecular weight heparin. (This metric for 2011/12 has been measured against where patient data has been loaded electronically).	Health and Social Care Information Centre data	100% (90% national target)	NHS funded acute care 94.2% (Q3 data) 2012/13 Range over Q3 74.8%-100%	97%	90%	92.3% NB: Last 2 years data collected against all patients admitted rather than a single day audit G
Comment: Patients undergoing surgery can be at risk of VTE (venous thromboembolism). Those assessed at risk can have the correct precautions, including compression stockings and low molecular weight heparin. QVH intends to take the following actions to improve this 92.3% score, and so the quality of its services by, continuing to complete the national 'safety thermometer' audit monthly; and report at ward level on VTE risk assessment compliance. The safety thermometer provides wards with a rate of harm-free care provided to patients, an aspect of which includes the assessment of patients for VTE risk on admission and after 24 hours following admission, and takes into account whether any prescribed medications were administered.						
Nutritional assessment within 24 hours of admission	Three monthly internal audit	100%	N/A	99%	100%	96% A
Comment: Maintenance of nutrition is important for physical and psychological wellbeing. When illness or injury occurs, nutrition is an essential factor in promoting healing and reinforcing resistance to infection. During 2012/13 this has been monitored on a quarterly basis, identifying that a few patients had not had their assessment completed within the required time. As a result we are going to return to auditing this measure on a monthly basis for 2013/14 and, as we have not met our expected high standard, have given an amber rating to this measure.						
Theatre lists starting with a surgical team safety briefing	Monthly internal audit	100%	N/A	83%	86%	93% A
Comment: A whole-team safety briefing with surgical, anaesthetic and nursing staff before theatre lists begin improves communication, teamwork and patient safety in the operating theatre. We are pleased to see that during 2012/13 this process, which is there to improve safety, has become more embedded as routine practice.						
Use of the WHO Safer Surgery checklist	Monthly internal audit	100%	Sign in	83%	96%	99.2%
			Time out	66%	84.8%	99.2%
			Sign out	55%	62.9%	98.3% G
Comment: The correct use of a checklist prior to anaesthesia and surgical incision reduces 'never events' such as wrong-site surgery. As with the surgical team safety briefing, this measure is there to improve patient safety and 2012/13 has seen this become embedded into routine practice.						
Development of pressure ulcer grade 2 or over (per 1000 spells)	Internal audit	0	0.84 / 1000 admissions (SEC Jan 12)	0.5/ 1000spells (total number = 9 cases)	0.5/1000 spells (total number = 8 cases)	0.2/ 1000 spells (total number = 3 cases) G
Comment: Pressure ulcers can cause serious pain and severe harm to patients and cost the NHS billions of pounds each year to treat. In the majority of cases they can be prevented if simple measures are followed. These figures are for hospital acquired injury and we are pleased to see that we achieved a reduction on the number of cases from previous years. This would indicate that staff are reviewing patients and taking relevant action to prevent harm occurring.						
Patient falls, including falls associated with harm (actual number)	Internal audit	0	2.2 / 1000 admissions (SEC SHA Jan 12)	82 falls 4.8/1000 spells 31 causing harm 1.8/1000 spells	56 falls 3.4/1000 spells 20 causing harm 1.2/1000 spells	64 falls 3.9/1000 spells 26 causing harm 1.6/1000 spells A
Comment: New falls assessment procedures have been introduced, including alerting all staff to patients at risk. Actions of ward staff are reviewed following a fall. While our incidents of harm have increased, no falls resulted in major harm, two falls resulted in moderate harm and the remainder minor harm such as a scratch or graze. In many cases a fall is due to the patient's wish to be more mobile and we have seen an increase in this type of fall as the type of injuries change and we manage younger patients with amputations who aim to be as active as possible.						

Patient safety indicator and why we measure it	How the data is collected	Our target	Benchmark	2010/11 result	2011/12 result	2012/13 result
Number of reportable MRSA bacteraemia cases	Internal audit	1	N/A	2	2	2 A
Comment: MRSA in the blood may be a hospital acquired infection and is a particular risk in patients with burns (the two cases this year were both burns patients). Each case is thoroughly investigated by root cause analysis and areas for improvement are identified. In both instances of MRSA bacteraemia the patients went on to recover and were discharged home.						
***Number of reportable Clostridium difficile cases**	Health and Social Care Information Centre data	0	National average 2011/12 21.8/100,000 bed days Range 0-51.6/ 100,000 bed days	Total = 6 30.7/100,000 bed days	Total = 0 0/100,000 bed days	Total = 0 0/100,000 bed days G
Comment: Clostridium difficile may be a hospital acquired infection. Each case is thoroughly investigated by root cause analysis. QVH intends to take the following actions to maintain this zero number score, and so the quality of its services by reviewing our antibiotic policy to ensure we maintain a low tolerance towards patients acquiring Clostridium difficile infections.						
Patients receiving all correct physiological monitoring during admission	Internal fortnightly audit of 10 patient records	100%	N/A	80% (2010)	80% (2011)	96% A
Comment: Monitoring of pulse, blood pressure, respiratory rate, temperature, pain and sedation is important to detect and prevent physiological deterioration of patients. We changed our audit approach this year to ensure we collected information in real time rather than after the event. Our improving score shows that staff have responded to previous feedback and that our approach this year, which has meant we have been able to give more immediate feedback to staff, has improved patient assessment.						
Percentage of staff witnessing harmful errors, incidents or near misses in the last month	National staff survey	N/A	30% national average acute specialist trusts 2012	36%	30%	31% A
Comment: Ideally no errors, incidents or near misses should occur. Where these are known about staff will report them for investigation.						
Percentage staff uptake of seasonal influenza vaccine	Internal audit	>60%	National rate 34.2% 2010	49.7%	59%	52.3% A
Comment: Frontline staff uptake of influenza vaccine is crucial in ensuring that the organisation is able to maintain services during an influenza outbreak and supports delivery of our emergency and business continuity plans. It was disappointing that our staff uptake rate was lower in 2012/13, although it did exceed the 50% target expected by NHS South England. For 2013/14 we will review our approach and ensure that we have more roving clinics during the early part of the vaccination programme, something we were not able to achieve in 2012/13.						

Clinical effectiveness

As a provider of specialist surgical services to a distinct group of patients, our services are often not included in national measures and audits of clinical effectiveness which rightly tend to focus on outcome measures for common diseases such as heart or lung disease, common cancers and common procedures such as orthopaedics and colorectal surgery.

As an organisation we are prioritising the development of measures of clinical outcome in our specialist services which will provide information to patients, clinicians, commissioners, regulatory bodies and others about the quality of service. Much of this work remains in development and we are aiming in 2013/14 to be able to provide information by consultant on their clinical results alongside patient reported outcome measures.

Below are some current examples of how we quality assure our work.

Guidance produced by the National Institute for Health and Clinical Excellence (NICE) is used to support clinicians in their decisions and provides a benchmark for audit. At QVH we use audit to embed clinical quality across all levels of the organisation. Our audit team works with our specialty teams to ensure that relevant audit is undertaken and results fed back to teams within the organisation.

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

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

All specialities						
Clinical effectiveness indicator and why we measure it	**How we measure it**	**Target**	**Benchmark**			
In-hospital surgical mortality	Continuous monitoring of PAS data	N/A	N/A	2010 0.021%	2011 0.015%	2012 0.007% G
Comment: Because of our specialist work it is not possible to present a comparable hospital standardised mortality ratio. We do, however, monitor death rates in burns care and surgery. The death rates presented here represent only one death this year, and one death can make a large difference to the rate. All deaths at QVH are reviewed within specialties and in a multidisciplinary forum.						
***Percentage of patients aged 0-14 readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period**	Health and Social Care Information Centre data	N/A	England 2010/11 10.15 (range 0.00 to 49.74) Acute specialist trust 7.98 (range 0.00 to 16.06)	2009/10 6.85	2010/11 8.71	2011/12 Awaiting publication
Comment: Data for 2011/12 awaiting publication. QVH intends to take the following actions to maintain the 8.71% score, and so the quality of its services by improving discharge information to patients, and raising awareness amongst clinicians; continuing to audit and feedback to a trust-wide audience; and continuing to provide information on individual readmissions to clinical specialty groups on a monthly basis for further analysis and review.						
***Percentage of patients aged 15 and over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period**	Health and Social Care Information Centre data	N/A	England 2010/11 11.42 (range 0.00 to 53.31) Acute specialist trust 9.52 (range 0.00 to 15.33)	2009/10 16 and over 10.24	2010/11 16 and over 9.71	2011/12 Awaiting publication
Comment: Data for 2011/12 awaiting publication. QVH intends to take the following actions to maintain the 9.71% score, and so the quality of its services by, improving discharge information to patients, and raising awareness amongst clinicians; continuing to audit and feedback to a trust-wide audience; and continuing to provide information on individual readmissions to clinical specialty groups on a monthly basis for further analysis and review.						

All specialities						
Clinical effectiveness indicator and why we measure it	**How we measure it**	**Target**	**Benchmark**	**2010/11**	**2011/12**	**2012/13**
Unexpected return to theatre within 7 days	Continuous monitoring of PAS data (change of methodology April 2010)	<1%	N/A	0.83%	0.84%	1.02% A
Comment: A patient may have to unexpectedly return to theatre because of post-operative bleeding, infection or other complication. We have noticed a slight increase in the unexpected returns to theatre within seven days – although this rate is still low at 1.02%. This is due to an increase in the number of complex surgical procedures requiring free tissue transfer. It is well recognised that in order to get a high success rate in the long term a small number of patients will require a return to theatre in the first seven days to re-inspect the delicate anastomosis (join) between blood vessels that keeps the free tissue transfer alive.						
Unexpected readmission to QVH within 28 days following discharge	Continuous monitoring of PAS data (change of methodology September 2010)	<1.5%	N/A	1.04%	1.08%	1.45% (2012) 1.48% (2012/13) G
Comment: This may be due to wound complications or other complication from surgery. Due to the increase in complex surgery we are not surprised that this rate has increased on last year and we intend to improve our discharge information to patients, as early recognition of symptoms and good care on discharge can influence whether a readmission is required.						
Unplanned transfer out of QVH for additional care	Internal audit	<0.5%	N/A	0.35%	0.28%	0.27% G
Comment: We are supported by surrounding trusts in the provision of specialist services such as respiratory medicine and cardiology, which we are unable to provide. We monitor our rates of unplanned transfer to surrounding trusts for these services. In the main it is complex care that results in a transfer out and we are pleased to see our rate has not increased with the increase in complex surgery.						

Burns care

In 2012 the burns centre accepted 949 adult burns referrals, an increase from 905 in 2011. Of these, 177 patients required inpatient care, of which 21 needed treatment in our intensive care unit (ICU). Over this year the burns centre was able to admit every clinically appropriate referral from our catchment area.

The mortality rate for adult burns inpatients in 2012 was 4.6%, which equated to 10 patients. An additional burns patient died 17 days post discharge from the burns centre. There was also one death of a patient who was admitted for reconstruction following major skin loss from a skin disease. All of these patient deaths were expected due to the severity of their injuries in conjunction with other survival indicators such as age and co-existing morbidities.

All patient deaths are discussed at burns multidisciplinary governance meetings so that any learning points can be built upon. If it is thought, either by the team or by the clinical audit lead, that further review and discussion is required then the patient's case is subsequently presented at a joint hospital clinical audit meeting.

We accepted 678 paediatric burns referrals during 2012, 125 of whom required inpatient care on our paediatric ward. QVH aims to enable all burn injuries to heal within 21 days. For 2012 the average healing time for paediatric burns was 16 days and 79% of paediatric burns were healed within 21 days.

All cases are discussed within the burns multidisciplinary team meeting. Patients likely to exceed our 21 day target for healing are reviewed by a burns consultant with a view to proceeding to surgery to close the wound.

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2010/11	2011/12	2012/13
Burn wounds healing within 21 days	Prospective database of all adult burns	100%	N/A	77%	72%	73%
Average time for burn wound healing		< 21 days	N/A	16 days	16 days	14 days
Comment: Burns healing in less than 21 days are less likely to be associated with poor long term scars. A shorter burn healing time may reflect better quality of care through dressings, surgery and prevention of infection. The burns service has a 26% 'did not attend' rate for follow-up, so the percentage healing within 21 days is likely to be higher.						
Average length of inpatient stay per percentage burn	Prospective database of all adult burns	<75 years old 1 day	N/A	<1 day	1 day	1.5 days
		>75 years old 2 days	N/A	2 days	2 days	2 days
Comment: The length of inpatient stay of burns patients is related to the size of their burn, measured as a percentage of their body surface area. We aim that, on average, adult patients under the age of 75 should require 1 day inpatient stay per 1% burn. Over 75 the length of stay is often complicated by the requirement of complex social care packages which take time to arrange.						

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

Our plastic surgery clinical directorate is one of the largest in the country and generates a significant part of the surgical activity within the trust. Our team of 18 specialist consultants are supported by a wider network of junior surgeons, specialist nurses, occupational therapists, physiotherapists and speech and language therapists.

Breast surgery

QVH is the major regional centre for complex microvascular breast reconstruction, either at the same time as a mastectomy for breast cancer (immediate) or after all treatment has been completed (delayed). Our integrated team of consultants and specialist breast care nurses provide a wide range of reconstructive options and flexibility. Surgery is also undertaken to correct breast asymmetry and congenital breast shape deformity.

Breast reconstruction after mastectomy using free tissue transfer – flap survival

The 'gold standard' for breast reconstruction after a mastectomy is a 'free flap' reconstruction using microvascular techniques to take tissue, usually from the abdomen, and use it to form a new breast. This technique has greater patient satisfaction and longevity but carries greater risks of failure than an implant or pedicled flap reconstruction, thus it is important that we monitor our success. If the abdomen is insufficient, tissue can be utilized from the inner thigh or the bottom as a free flap for breast reconstruction.

In 2012 the breast team performed a total of 179 flaps in 157 patients. Of these, 164 flaps were from the abdomen and 15 from the thigh. Breast reconstruction was performed immediately after the mastectomy in 47 cases (26.3%). Of the 157 women operated on, 22 (14%) had both breasts reconstructed.

Our total failure rate was one flap out of 179 performed (0.56%). All flaps from the abdomen survived (0% total failure) while one flap from the inner thigh did not (6.66% total failure). These figures continue the year-on-year improvement in free flap survival within the breast team.

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2010/11	2011/12	2012/13
Breast reconstruction after mastectomy using free tissue transfer – flap survival	Continuous prospective electronic database	100%	95–98% (published literature) 98% BAPRAS 2009	98.4%	99.2%	99.44%
Comment: The 'gold standard' for breast reconstruction after a mastectomy is a 'free flap' reconstruction using microvascular techniques. The breast team's results continue the year-on-year improvement in free flap survival.						

Hand surgery

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

The department now comprises five full-time hand consultants and a hand therapy department with outreach clinics for consultants and therapists. Consultant outreach clinics are held at Medway, Dartford, Faversham, Hastings, Horsham and Brighton.

The geographical intake for acute trauma comes from most of South East England and South East London. Besides acute trauma, elective work comprises secondary reconstruction following trauma, paediatric hand surgery and arthritis and neurological conditions. In addition, vascular problems are also handled.

Pyrocarbon implants completed by Mr Pickford show comparable results to those reported in international published studies. The use of Xiapex for Dupuytren's contracture, a new procedure adopted by all of the hand surgeons, is the subject of an on-going audit, led by Mr Belcher, into its use and cost-effectiveness. QVH is one of the leaders in the south east for this procedure.

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2010/11	2011/12	2012/13
Rupture rate following repair of flexor tendon injuries	On-going monthly audit between hand surgeons and hand therapists, with complication data collected via a trauma database	0%	9–13% (published literature)	4%	3.5%	5%
Comment: Hand surgery accounts for 80% of the trauma workload of the hospital, with flexor tendon repair the most common injury requiring surgery. In 2012 we carried out 255 primary repair of flexor tendon injuries Monitoring rates of rupture of the repaired tendon is one way of monitoring quality of surgery and post-operative therapy.						

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

Skin cancer care and surgery

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

In the past, QVH has produced data for block lymph node dissections in the treatment of skin cancer. However, we have ceased producing this data as the distinction between the normal clinical outcome and a mild complication is difficult to distinguish, and accordingly these data will no longer be published.

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2010/11	2011/12	2012/13
Complete excision rates in Basal Cell Carcinoma (BCC)	Audit of two months activity (286 BCC cases)	100%	88.9–95.3% (published literature)	92.0%	90.7%	91.7%
Comment: BCC is the most common cancer in Europe, Australia and the USA. Management usually involves surgical excision, photodynamic therapy (PDT), curettage, immuno-modulators, or a combination. Surgical excision is highly effective with a recurrence rate of 2%. Complete surgical excision is important to reduce recurrence rates. This may not be possible because of the size or position of the tumour or because the incomplete excision will only be evident with histological examination of the excised tissue. The high rate of complete excision for QVH is particularly pleasing as 40% of our referrals are from dermatologists who refer more complex cases.						
Complete excision rates in malignant melanoma	Audit of two months activity (42 melanoma cases)	100%	75% NICE guidance	100%	90%	95.6%
Comment: Melanomas are excised with margins of healthy tissue around them, depending on the type, size and spread of tumour. These margins are set by national and local guidelines and each case is discussed in a multidisciplinary team (MDT). Total excision may not be possible because of the health of the patient or the size, position or spread of the tumour, and the MDT may recommend incomplete excision.						

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

Our head and neck services are recognised, regionally and nationally, for the specialist expertise offered by our large consultant body. In particular, QVH is the Kent and Sussex surgical centre for head and neck cancer and is recognised by the Royal College of Surgeons as a training centre for head and neck surgical fellows.

We also have the largest maxillofacial and general prosthetics laboratory in the country, which provides a wide range of support to orthodontists and maxillofacial and plastic surgeons. Our specialist orthodontic team advises and treats children and adults with complex orthodontic problems such as facial deformity and anomaly, hypodontia, malalignment of the jaws and positional problems of the teeth.

For 2013 we have chosen to repeat the same indicators which were used in the 2012 quality account. The data collection process has changed for the data relating to nerve injury following removal of third molar teeth.

Patient satisfaction

Questionnaires are given to all patients who have completed orthodontic treatment. The aim of this rolling prospective audit is to measure the level of patient satisfaction using a questionnaire, either following completion of orthodontic treatment or at one-year post treatment.

During 2012, 222 patients completed a patient satisfaction questionnaire, 78 more than the previous year.

The majority of patients (93%) were completely satisfied with the result of their treatment, and the remaining 7% were fairly satisfied; 98% of patients were happy with the appearance of their teeth after treatment; 75% reported improved self-confidence; 94% would recommend a similar course of treatment to a friend; 99% of patients felt that they were given sufficient information regarding their proposed treatment; 100% of patients said that they were glad they undertook their course of treatment; and only 30% of patients felt that treatment took longer than expected.

Questionnaires are also given to every patient who has completed treatment with a combination of orthodontics and orthognathic surgery.

Over the past year, 88% of these patients described their orthodontic and surgical service and care as excellent, and 12% described it as good. We have recorded many positive patient comments regarding the team, the process and the hospital as a whole.

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2010/11	2011/12	2012/13
Facial nerve injury rates in condylar fracture (jaw fracture) repair	Trauma Card (continuous trauma and complications database)	0%	17%	9%	0%	5.8%
Comment: We monitor damage to the facial nerve during open fixation of mandibular fractures. We continue to have a zero permanent nerve injury rate.						
Nerve injury rates in third molar (wisdom tooth) extraction and mandibular (jaw) fracture surgery		0% 0%	Temporary numb lip 5-10% Temporary numb tongue 2-8%	4.4% 4.4%	5% 9%	4.7% On-going numb lip 0.79% 8.7% On-going numb tongue 1.2%
Comment: Wisdom tooth extraction is a commonly performed procedure. A recognised complication is inferior dental or lingual nerve injury which may be temporary or permanent. In 2012 we treated 695 patients for extraction of the third molar teeth. The rates for 2011/12 have been collected initially by telephone interview, rather than direct examination as in previous years, which may explain the slight change in rates for temporary numbness.						
Patient reported outcome measures (PROM) in Orthognathic surgery (correction of bony jaw abnormalities)	Prospective database of all orthognathic surgery patients	How do you rate the orthodontic service and care?		**2010** 88% excellent; 12% good	**2011** 80% excellent; 10% good; 10% average	**2012** 90% excellent; 10% good
		How do you rate the surgical service and care?		82% excellent; 18% good	90% excellent; 10% good	92% excellent; 8% good
		How satisfied are you with facial appearance?		75% very satisfied; 25% satisfied	70% very satisfied; 10% satisfied	74% very satisfied; 26% satisfied
		How satisfied are you with dental appearance?		91% very satisfied or satisfied	80% very satisfied; 10% neither satisfied or dissatisfied; 10% dissatisfied	85% very satisfied; 15% satisfied
Comment: This PROM has been developed to look at patient satisfaction with the orthodontic surgery service and satisfaction with the appearance, dentition and face following treatment.						
Peer Assessment Rating (PAR) index for orthodontic treatment	Continuous prospective data collection on all orthodontic patients	>70% = very high standard < 50% = poor standard		95%	95%	95%
Comment: The PAR index is a fast, simple and robust way of assessing the standard of orthodontic treatment that an individual provider is achieving. The index is designed to look at a large group of patients rather than an individual patient's outcome.						

Corneoplastic and oculoplastic surgery

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

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

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2010/11	2011/12	2012/13
Percentage of patients achieving vision better than 6/12 after cataract surgery without other eye disease	Annual audit of 100 patients	100%	96% (UK EPR)	96%	96%	100% with correction 90% unaided

Comment: There were 959 cases of phacoemulsification for cataracts recorded in 2012. Departmental audit shows that cases of post-operative eye infection are extremely rare and well below national average rates. We monitor the number of these patients who achieve significant improvement to the vision in that eye.

Anaesthetics

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

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2010/11	2011/12	2012/13
Percentage of patients requiring no recovery room intervention following anaesthesia	Continuous prospective audit of all inpatient recovery room procedures	100%		83%	79%	84%

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

Patient experience

Continuing to improve and ensure that patients have a good experience when being cared for at QVH remains a key objective for the organisation.

The findings from the 2012 national NHS inpatient survey have been published by CQC. The survey asked the views of adults who had stayed overnight as an inpatient in June, July or August 2012. The questionnaire was sent to 850 patients, and we had a response rate of 50%.

The patients were asked what they thought about different aspects of the care and treatment they received at QVH. Results from the survey show that QVH achieved the highest score out of all 156 acute hospital trusts in England for how well patients rated their experience of being in hospital.

During 2012/13 we commenced a new patient experience group that looks at all information relating to a patient's experience while at the hospital. We commenced the NHS friends and family test for all inpatients in December, and followed in January collecting the same patient experience information from our minor injuries unit attendees and those who visit our trauma clinic.

Within our outpatient departments we have collected information on waiting times and information provided to patients about waiting. Our plan is to roll out the NHS friends and family test methodology in outpatient departments during 2013, and be able to report by clinic specialty. During 2013/14 we also plan to roll out the friends and family test question to our therapy and day surgery patients.

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

Patient experience indicator and why we measure it	How the data is collected	Target	Benchmark	2010/11	2011/12	2012/13
Failure to deliver single sex accommodation (occasions)	Continuous internal audit	0	N/A	1	0	0 G
Comment: In all wards outside of theatre recovery areas and critical care we endeavour to deliver care in male and female segregated wards or bays. Failure to meet this requires formal reporting. We are pleased to have been able to maintain segregated accommodation during 2012/13 and this has been achieved because we have a number of single rooms available for use.						
Complaints per 1000 spells	Continuous internal audit	0	N/A	4.8	4.4	4.4 G
Comment: We monitor complaints about the quality of service we provide to help us continuously improve. All of our complaints are reviewed by the executive team and all complaints are investigated. Where we identify that the complainant remains dissatisfied we will actively support them in going to the ombudsman for assurance their complaint has been appropriately responded to.						
Claims per 1000 spells	Continuous internal audit	0	N/A	0.8	0.8	0.7 G
Comment: This reflects legal action against the trust by patients/carers, and includes all cases, whether founded or unfounded. All findings from claims is fed back to the consultant involved. During 2013/14 we intend making this information more widely available so that others can learn from incidents where a claim is upheld.						
Overall experience	National inpatient survey	10	Range 7.2-9.0 2012	N/A	N/A	9.0 G
Comment: This is a new measure from the national NHS inpatient survey that was introduced this year. QVH were delighted to receive the highest score of all trusts for this measure.						
Percentage of patients who felt they were always treated with respect and dignity	National inpatient survey	10	9.7 highest national score 2012	9.5	9.7	9.6 A
Comment: Scoring has been altered from % to a scale of 1-10. How patients feel their dignity was respected is important in being able to measure the quality of service the trust provides.						

Patient experience indicator and why we measure it	How the data is collected	Target	Benchmark	2010/11	2011/12	2012/13
PEAT scores	National Reporting Learning Service	Excellent	All trusts 2010/11			A
				2010	**2011**	**2012**
Environment			25%	Good	Good	Good
Food			57%	Excellent	Excellent	Excellent
Privacy and dignity			48%	Good	Excellent	Excellent
Comment: PEAT is an annual assessment of inpatient healthcare sites in England with more than 10 beds. It is self-assessed and inspects standards across a range of services including food, cleanliness, infection control and patient environment (including bathroom areas, décor, lighting, floors and patient areas). The benchmark is the % achieving excellent.						
Percentage of patients who rated their quality of care as good or excellent	In-house discharge questionnaire	100%		98%	99%	98% G
Comment: We invite all patients to complete a questionnaire about their quality of care on discharge. During 2013/14 this score will be supplemented by the NHS friends and family test question which asks if patients would recommend the ward they visited to their family and friends.						
***Responsiveness to inpatients' personal needs**	CQUIN score	>82	76.5 national average 2012 range 72.2-88.2 SEC SHA	87.3	87.8	88.2 G
Comment: This is an amalgamated score from five questions within the national NHS inpatient survey and is used as a CQUIN measure. QVH intends to take the following actions to improve the 88.2% score, and so the quality of its services by, ensuring that staff understand the expectations for delivering excellence in care to patients through our culture and values which have been rolled out during 2012/13.						
Percentage of patients who reported sufficient privacy when discussing their condition or treatment	In-house discharge questionnaire	100%	93% highest score achieved in national inpatient survey	94%	97%	98% G
Comment: That patients felt their privacy was respected when discussing their condition is a key measure of the quality of care delivered.						
Satisfaction with anaesthetic service	Ward discharge survey (8 months data)	100%	N/A	98%	98%	96.5% A
Comment: Those who rated their anaesthetic service as good or excellent.						
***Staff recommendation of the trust as a place to work or receive treatment**	National staff survey		4.06 national average acute specialist trusts 2012 range highest 4.24	3.94	4.02	4.24 G
Comment: Data is taken from the NHS staff survey results. This indicates an employee's view of the quality of care delivered by their organisation (scale 1-5). QVH intends to take the following actions to improve the 4.24 score, and so the quality of its services by ensuring that staff understand the expectations for delivering excellence in care to patients through our culture and values which have been rolled out during 2012/13.						

Performance against key national targets for 2012/13

Performance against national targets is set out in annex B.

Statements from third parties

During April 2013, third parties were asked to comment on the accuracy of the quality accounts and were sent a draft of the document. Amendments from the draft include a change to the final priorities for 2013/14 following release of the Francis report on Mid Staffordshire NHS Foundation Trust, updating of final figures to ensure that full year data is captured where possible and editing or the addition of explanatory text.

Statement from Healthwatch West Sussex

Thank you for inviting Healthwatch West Sussex (HWWS) to provide a statement on the 2012/13 quality accounts for QVH. As you may know, HWWS has recently appointed its board and is in the process of determining its final representation and liaison arrangements with various strategic forums. Its commentary on the quality accounts is therefore limited in scope this year.

I confirm that to the best of my knowledge the Queen Victoria Hospital NHS Foundation Trust quality accounts contain accurate information. QVH should be congratulated for the extensive work carried out to improve services during the current financial climate.

2011/12 priorities

I agree that good progress was made in two of the 2011/12 priorities and welcome that they will continue to look for improvements in these areas. I agree with their decision to repeat the other two during 2012/13.

Current situation

In the latest national NHS inpatient survey QVH achieved the highest score of all 156 acute hospital trusts in England for how well patients rate their experience of being in hospital. This is a tremendous achievement as the collection of buildings which comprise the hospital are pre 1950 or 1960. Significant progress is being made in upgrading facilities across the hospital estate. The new outpatient clinic facility and the six new state-of-the-art operating theatres will lead to improved service delivery. Healthwatch also welcomes the fact that from April 2013 meetings of the QVH board of directors will be held in public.

Statement from Health and Adult Social Care Select Committee

I am writing to let you know that the Health and Adult Social Care Select Committee (HASC) will not be providing any commentary for your quality account this year. Our outgoing HASC liaison member for QVH had no specific comments to make on your draft quality account and, as the committee did not carry out any scrutiny of your trust or its services during 2012/13, it is difficult for us to provide a comment.

Statement from Horsham and Mid Sussex Clinical Commissioning Group and Crawley Clinical Commissioning Group

Thank you for the quality report for 2012/13. We welcome the opportunity to comment on progress against your key priorities for 2012/13.

I have reviewed the report with Victoria Daley, the CCG's Head of Quality, and as lead commissioner for services have included comments from other commissioners where possible.

We have checked the report for accuracy and agree that it is accurate from information gained through a variety of sources including regular quality review meetings and inspection of the CQC and NHSLA websites. We noted the trust's very good NHSLA score of 49 out of 50 on the website.

Your process in producing the report complies with the guidance and gives an overview of the services provided and priorities for 2013/14.

We congratulate you on your achievements and note the areas where substantial improvement has occurred, whilst acknowledging the work necessary in the two outstanding areas of patient experience in outpatients and consent to treatment prior to planned surgery.

Priority 2 – Patient consent prior to day of surgery

This is an area where patient safety can be improved by further attention to who gains consent and the quality of information and choices available to patients regarding treatment options. These good practices underpin the time and place where consent is gained.

Priorities for 2013/14

The two further priority areas for this year, namely data completeness for cancer outcomes datasets and outpatient follow ups by nurses and allied health professionals are key areas where progress can be made in improving the service for patients.

Trust leadership

The trust board and key quality committees review all data for services provided. There appear to be good governance systems and processes in place and service reviews take place on a regular basis.

Significant risks and incidents are reported through the trust board and action plans monitored to mitigate risks.

Clinical audits

There have been four national clinical audits and four national confidential enquiries. We note the rationale where the trust has not taken part in audits, and especially commend the in house mortality monitoring which has been published and shared.

CQC inspections

The trust has been authorised by the CQC as a provider of safe services for the public.

Outcome 21 in the CQC inspection report outlines where the trust needs to improve its care of personal record keeping, including medical records. We note you have submitted a report to the CQC on actions to improve record keeping. This will be monitored by the CCG through the quality review meetings to ensure improvements take place.

Patient safety

Your incident reporting and investigation demonstrates that the trust takes seriously its responsibilities in this area, and has systems to ensure that the learning from these incidents is shared and embedded. There have been a very small number of incidents where theatre processes need tightening up to prevent avoidable incidents. Audits and action plans are in place and will be monitored to prevent further incidents.

The increase in pre-operating safety briefings from 80% to 93% is good progress in this respect.

It is disappointing to note you exceeded your MRSA target of one, but are assured that you have improved your processes in line with the extra vigilance needed when dealing with burns patients and other specialist services.

Clinical effectiveness

The types of patients you care for make it doubly important that you measure the outcome of treatments and continually strive to improve the care provided. A good start is with individual consultant success rates alongside patient reported outcome measures. Although you are not required to report or publish your mortality rates, you do report in house and monitor this important patient safety measure.

The clinical outcome measures in breast, burns, eyes and skin cancer are commendable and go some way towards explaining the high patient satisfaction rates achieved.

Patient experience

Data is routinely collected in house over and above the statutory requirements, and it appears that action is taken to address deficits. The creation of an overarching patient experience group to co-ordinate and collate data is helpful in determining a cohesive trust-wide response.

Conclusion

The trust has made progress against its priorities for 2012/13 and has recognised the need to carry forward further development in two key areas for 2013/14.

The specialist nature of trust's work means that progress can be slow in some areas, however the leadership and clinical engagement required for moving to the next phase is in place. The focus upon reduction in avoidable clinical incidents and MRSA elimination is challenging. There is also the need to streamline pathways and processes to reflect the changing nature of commissioned services, where better outcomes for patients mean that more resources are available to treat more people.

Statement from West Kent Clinical Commissioning Group

No response had been received from West Kent Clinical Commissioning Group prior to signing of the report.

Statement from the QVH Council of Governors

The QVH Council of Governors takes a close interest in all forms of the patient experience within the hospital. This covers the general experience of attending and being treated at the hospital to the specific issues of patient safety and clinical outcomes. The governors have multiple areas of interaction with the management and activities of the hospital and with the patients.

A governor representative attends the meetings of the board of directors reporting back to the governors. Similarly a governor attends the meetings of the quality and risk committee which reviews all quality and risk activities within the trust on behalf of the board. One governor is responsible for the overview of the activities of the external auditors and the audit committee and is also on a board of directors' working group which reviews the effectiveness of board financial and operational reporting. the governors' steering group meets monthly with the executive reviewing operational reports and discussing any issues arising.

There are regular patient experience reports which cover all aspects of the patient experience and are presented to the board of directors and the council of governors. Governors attend meetings of the patient experience group, formed during 2012 and chaired by the director of nursing and quality, which monitors patient experience and maintains an action plan for improvements. There are other areas of involvement including individual governor tours of specific areas of the hospital and governor attendance on some of the regular management inspections which cover cleanliness and safety issues within all departments of the hospital.

During 2012/13, the governors have been very pleased to note the results of the national inpatient and outpatient surveys undertaken throughout the NHS. QVH has maintained consistently high scores on these surveys and is working to improve those areas which do not have the highest scores.

The work the governors undertake gives us a clear and comprehensive view of the activities within QVH and of the quality of the patient experience. We have reviewed the quality accounts produced for 2012/13 and are satisfied that they give an accurate and reliable picture of the quality of QVH's activities. We also agree with the priorities for improvement. The governors pay particular attention to the performance of the outpatient clinics and, whilst progress has been made in 2012/13, it is agreed that communication of clinic waiting times is still a problem and that, therefore, this area remains a priority for 2013/14.

The management, staff and governors of QVH take pride in the high standard of care being achieved within the hospital. However, we are pleased to note that QVH is constantly striving to improve. The many operational reports produced are aimed at recording the positives but also at learning from the negatives.

Work is already underway within the trust to ensure that all recommendations from the Francis report which are relevant to QVH are actioned promptly. In the past two years a comprehensive review has been undertaken of the culture and values within QVH and the governors are assured that the cultural breakdown noted by the Francis report is highly unlikely to happen at QVH. We are confident that QVH has the highest quality of care as a key priority and that it will continue to maintain and improve upon the current excellent standard.

Independent Auditor's Report to the Council of Governors of Queen Victoria Hospital NHS Foundation Trust on the Annual Quality Report

We have been engaged by the council of governors of Queen Victoria Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Queen Victoria Hospital NHS Foundation Trust's quality report for the year ended 31 March 2013 (the "quality report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Emergency re-admissions within 28 days; and
- Cancer waits – 62 days from GP referral to first definitive treatment.

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 as issued by Monitor.

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

- The quality report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- The quality report is not consistent in all material respects with the sources specified in above; 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 Guidance for External Assurance on Quality Reports.

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 either refer back to the specified documents in the guidance, or list those documents below:

- Board minutes for the period April 2012 to May 2012;
- Papers relating to quality reported to the board over the period of April 2012 to May 2012;

- Feedback from the commissioners dated 09/05/2013
- Feedback from local Healthwatch organisations dated 10/05/2013;
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2013;
- The latest national patient survey dated 31/03/2013;
- The latest national staff survey dated 31/12/2012;
- Care Quality Commission quality and risk profiles dated 31/03/2013;
- The head of internal audit's annual opinion over the trust's control environment dated 14/05/2013; and

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

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

This report, including the conclusion, has been prepared solely for the council of governors of Queen Victoria Hospital NHS Foundation Trust as a body, to assist the council of governors in reporting Queen Victoria Hospital NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the annual report for the year ended 31 March 2013, to enable the council of governors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators.

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

Assurance work performed

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

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Testing key management controls;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the quality report; and
- Reading the documents.

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

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 impact 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 thereof, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Queen Victoria Hospital NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- 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 above; and
- The indicators within the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual.

KPMG LLP
Statutory Auditor
London
May 2013

Statement of directors' responsibilities in respect of the quality report

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

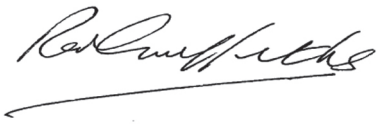
Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2012-13;
- 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 2012 – May 2013
  - papers relating to quality reported to the board over the period April 2012 – May 2013
  - feedback from Horsham and Mid Sussex and Crawley clinical commissioning groups dated 9 May 2013
  - feedback from council of governors dated 10 May 2013
  - feedback from Healthwatch West Sussex dated 10 May 2013
  - feedback from Health & Adult Social Care Select Committee dated 22 May 2013
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2013
  - the national patient survey, April 2013
  - the national staff survey, February 2013
  - the head of internal audit's annual opinion over the trust's control environment dated 22/05/2013
  - CQC quality and risk profiles dated 31/03/2013
- the quality report presents a balanced picture of the nhs foundation trust's performance over the period covered;
- the performance information reported in the quality report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm they are working effectively in practice;
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions and is subject to appropriate scrutiny and review; and
- the quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report (both available at www.monitor-nhsft.gov.uk/annualreportingmanual).

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

By order of the Board.



Peter Griffiths
Chairman
28 May 2013

Amanda Parker
Director of Nursing and Quality
28 May 2013

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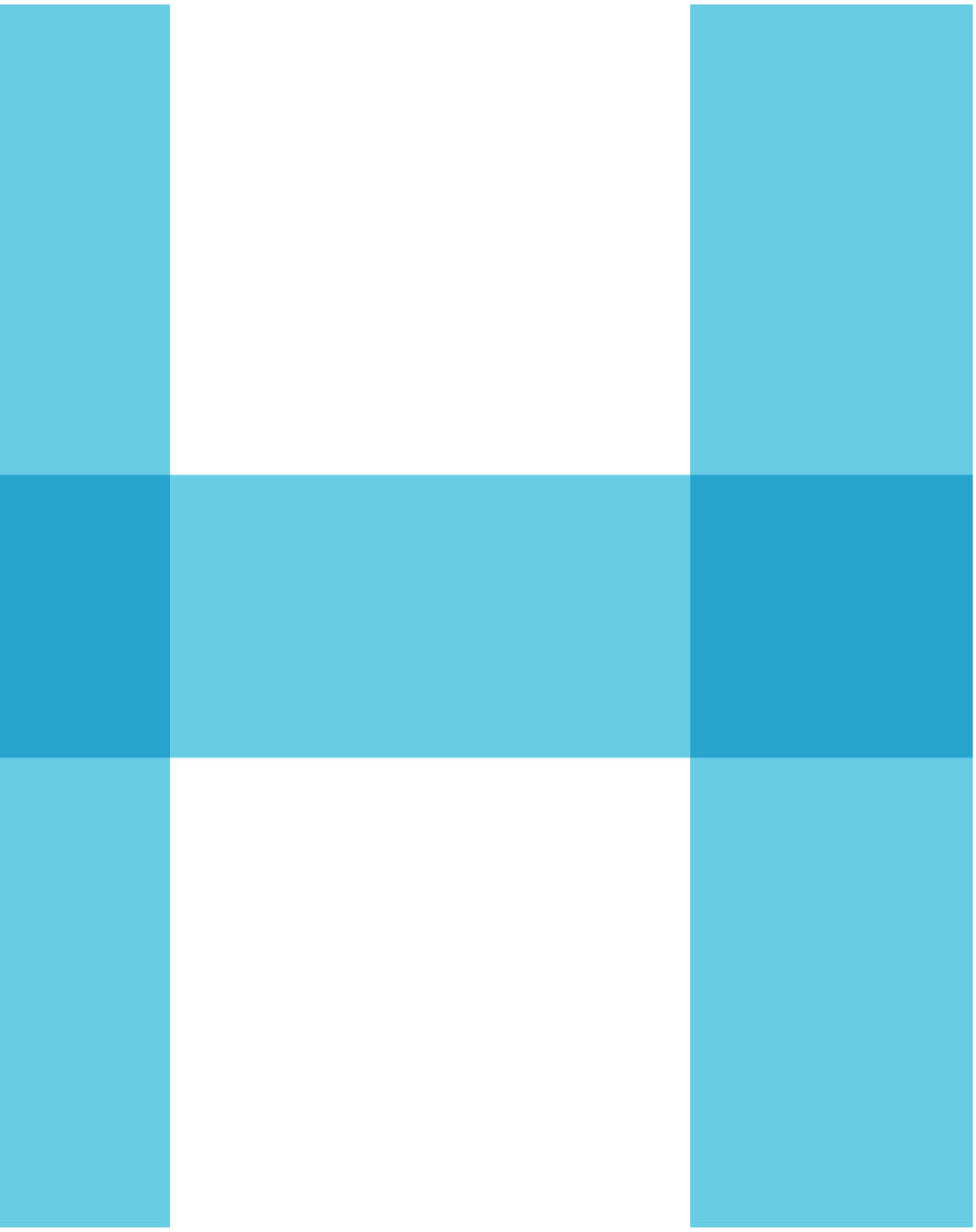

6.1 Statement of accounting officer's responsibilities

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

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. At the time of preparing the 2012/13 annual report, the position of chief executive was vacant, pending appointment from 1 July 2013. As part of the trust's interim leadership arrangements, the board of directors agreed that its Director of Nursing and Quality, Amanda Parker, would act as accounting officer for the purposes of these accounts. 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 the independent regulator of NHS foundation trusts ("Monitor").

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

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

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

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

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

Amanda Parker
Director of Nursing and Quality
23 May 2013

6.2 Independent auditor's report to the council of governors

We have audited the financial statements of Queen Victoria Hospital NHS Foundation Trust for the year ended 31 March 2013 on pages 60 to 85. These financial statements have been prepared under applicable law and the NHS Foundation Trust Annual Reporting Manual 2012/13.

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

Respective responsibilities of the accounting officer and the auditor

As described more fully in the statement of accounting officer's responsibilities on page 58, the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of whether the accounting policies are appropriate to the trust's circumstances and have been consistently applied and adequately disclosed, the reasonableness of significant accounting estimates made by the accounting officer and the overall presentation of the financial statements. In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of Queen Victoria Hospital NHS Foundation Trust's affairs as at 31 March 2013 and of its income and expenditure for the year then ended; and
- have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2012/13.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion the information given in the directors' report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report where under the Audit Code for NHS Foundation Trusts we are required to report to you if, in our opinion, the annual governance statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, 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 are not required to assess, nor have we assessed, whether all risks and controls have been addressed by the annual governance statement or that risks are satisfactorily addressed by internal controls.

Certificate

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

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

28 May 2013

6.3 Statements and notes

Foreword to the accounts

These accounts for the year ended 31 March 2013 have been prepared by Queen Victoria Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

Amanda Parker
Director of Nursing and Quality
23 May 2013

STATEMENT OF COMPREHENSIVE INCOME FOR THE PERIOD ENDED 31 MARCH 2013				
	Notes		**2012/13**	2011/12
			£000	£000
Operating income	2, 3, 4		**61,267**	55,887
Operating expenses excluding impairments	5		**(53,293)**	(52,579)
Impairments of property, plant and equipment			**(1,197)**	(1,765)
Operating surplus/(deficit) including impairments			**6,777**	1,543
Finance costs				
Finance income	9	20		16
Finance expense – unwinding of discount	18	(15)		(16)
Finance expense – other	19	(84)		(8)
PDC dividends payable		(935)		(861)
Net finance costs			**(1,014)**	(869)
SURPLUS/(DEFICIT) FOR THE YEAR	25		**5,763**	674
Other comprehensive income: (See statement of changes in taxpayers' equity on page 62)				
Revaluation gains/(losses) on property, plant and equipment			**81**	741
Impairment through revaluation reserve			**(6,387)**	(708)
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE PERIOD			**543**	707

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2013			
	Notes	**31 March 2013**	31 March 2012
		£000	£000
NON-CURRENT ASSETS:			
Intangible assets	10	**593**	93
Property, plant and equipment	11	**33,030**	30,706
Trade and other receivables	14	**–**	–
Total non-current assets		**33,623**	30,799
CURRENT ASSETS:			
Inventories	13	**390**	304
Trade and other receivables	14	**3,534**	2,223
Cash and cash equivalents	15	**8,137**	5,979
Total current assets		**12,061**	8,506
CURRENT LIABILITIES:			
Trade and other payables	16	**(5,169)**	(3,476)
Borrowings	20.1	**(250)**	–
Provisions	18	**(27)**	(29)
Other liabilities	17	**(129)**	(495)
Total current liabilities		**(5,575)**	(4,000)
NON-CURRENT LIABILITIES:			
Provisions	18	**(522)**	(465)
Long term borrowings	20.1	**(6,250)**	(1,000)
Total non-current liabilities		**(6,772)**	(1,465)
TOTAL ASSETS EMPLOYED		**33,337**	33,840
TAXPAYERS' EQUITY: (See statement of changes in taxpayers' equity on page 62)			
Public dividend capital		**12,212**	12,212
Revaluation reserve		**6,266**	12,808
Income and expenditure reserve		**14,859**	8,820
TOTAL TAXPAYERS' EQUITY		**33,337**	33,840

The accounts on pages 60 to 63 were approved by the board on 23 May 2013 and are signed on the board's behalf by:

Amanda Parker
Director of Nursing and Quality
23 May 2013

The notes on pages 64 to 85 form part of these accounts.

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY				
	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	**Total £000**
2012/13				
Taxpayers' equity at 1 April 2012	12,212	12,808	8,820	**33,840**
Surplus/(deficit) for the year	–	–	5,763	**5,763**
Transfers between reserves	–	(276)	276	**–**
Revaluation of property, plant and equipment	–	81	–	**81**
Impairments	–	(6,387)	–	**(6,387)**
Other reserves movements	–	40	–	**40**
Taxpayers' equity at 31 March 2013	12,212	6,266	14,859	**33,337**
2011/12				
Taxpayers' equity at 1 April 2011	12,212	14,014	6,899	**33,125**
Surplus/(deficit) for the year	–	–	674	**674**
Transfers between reserves	–	(1,247)	1247	–
Revaluation of property, plant and equipment	–	741	–	**741**
Impairments	–	(708)	–	**(708)**
Other reserve movements	–	8	–	**8**
Taxpayers' equity at 31 March 2012	12,212	12,808	8,820	**33,840**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2013				
	Notes		**2012/13**	2011/12
			£000	£000
Operating surplus/(deficit)			**6,777**	1,543
Non-cash income and expense				
Depreciation and amortisation	5		**1,786**	1,820
Impairments	5		**1,197**	1,765
Reversal of impairments	4		**(2,848)**	–
Non-cash donations			**(240)**	–
Dividend accrued, not received			**(65)**	–
(Increase)/decrease in inventories	13		**(86)**	(79)
Increase/(decrease) in trade receivables	14		**(1,311)**	229
Increase/(decrease) in trade and other payables	16		**1,693**	42
Increase/(decrease) in provisions	18		**55**	(399)
Increase/(decrease) in other liabilities	17		**(366)**	241
Net cash inflow from operations			**6,592**	5,162
Cash flows from investing activities				
Interest received	9	**20**		16
Payments to acquire intangible assets	10	**(374)**		(52)
Payments to acquire property, plant and equipment	11	**(8,496)**		(6,434)
Net cash used in investing activities			**(8,850)**	(6,470)
Cash flows from financing activities				
Loans from Foundation Trust Financing Facility	20.1		**5,500**	1000
Interest paid	19		**(84)**	–
PDC dividends paid			**(1,000)**	(680)
Increase in cash			**2,158**	(988)
Cash and cash equivalents at 1 April 2012	15		**5,979**	6,967
Cash and cash equivalents at 31 March 2013	15		**8,137**	5,979

Notes to the financial statements

1. Accounting policies

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2012/13 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

1.1 Income

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

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

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

1.2 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS pension scheme

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

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

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

1.3 Expenditure on other goods and services

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

1.4 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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

Measurement

Valuation

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

To this end, valuations of land, buildings and fixtures are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the balance sheet date. Revaluations are never less than triennial. The latest valuations were undertaken in 2013 as at the prospective valuation date of 31 March 2013 and were accounted for in the 2012/13 accounts.

Fair values are determined as follows:

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

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

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

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

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

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

Subsequent expenditure

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

Depreciation

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

The remaining economic lives of each element of each building are determined by an independent valuer and each element is depreciated individually. Currently, lives range from three to 70 years.

Plant, machinery and medical equipment are generally given lives of five, 10 or 15 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

In accordance with the NHS Foundation Trust Annual Reporting Manual, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

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 resulting from loss 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.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised.

Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

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

Land and buildings were revalued as at 31 March 2013 and the effect of that revaluation has been included in these accounts.

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 existing site rather than an alternative.

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

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

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

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

Donated assets

From 1 April 2011 NHS foundation trusts have adopted IAS 20 in accordance with the Treasury FReM. Donations are therefore recognised in income and a donated asset reserve is no longer maintained. Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.5 Intangible assets

Recognition

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

Internally generated intangible assets

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

Expenditure on research is not capitalised.

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

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

Software

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

Measurement

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

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

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

Amortisation

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

1.6 Inventories

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

1.7 Cash and cash equivalents

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

1.8 Trade receivables

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

1.9 Trade payables

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

1.10 Financial assets and financial liabilities

Recognition

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

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

De-recognition

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

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

Classification and measurement

Financial assets are categorised as 'loans and receivables'.

Financial liabilities are classified as 'financial liabilities'.

Loans and receivables

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

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

Interest on loans and receivables is calculated using the effective interest method and credited to the statement of comprehensive Income.

Financial liabilities

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

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

Impairment of financial assets

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

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

1.11 Leases

Finance leases

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

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

Operating leases

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

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Where land is leased for a short term (e.g. 10 years) and there is no provision for the transfer of title, the lease is considered to be an operating lease.

The trust as lessor

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

1.12 Provisions

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

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 18. The trust does not carry any amounts relating to these cases in its own accounts.

Other NHSLA schemes

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

1.13 Contingencies

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

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

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

1.14 Public dividend capital

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

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

1.15 Value added tax

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

1.16 Corporation tax

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

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

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

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

No corporation tax was charged to the trust for the financial year ending 31 March 2013.

1.17 Foreign exchange

The functional and presentational currencies of the trust are sterling.

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

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

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

1.18 Third party assets

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

1.19 Accounting standards issued but not yet applied

IASB standard and IFRIC interpretations

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

In some cases, the standards may be interpreted in the HM Treasury FReM and therefore may not be adopted in their original form. The analysis below describes the anticipated timetable for implementation and the likely impact on the assumption that no interpretations are applied by the HM Treasury FReM.

i) IFRS 7 – Financial Instruments: Disclosures – amendment
Offsetting financial assets and liabilities. This is an amendment to the standard to require additional disclosures where financial assets are transferred between categories (e.g. 'Fair Value through Profit and Loss', Loans and Receivables etc). Effective date of 2013/14 but not yet adopted by the EU.

ii) IFRS 9 – Financial Instruments
Financial Assets. Financial Liabilities. This is a new standard to replace – IAS 39 Financial Instruments: Recognition and Measurement. Two elements of the standard have been issued so far: Financial Assets and Financial Liabilities. The main changes are in respect of financial assets where the existing four categories will be reduced to two: Amortised Cost and 'Fair Value through Profit and Loss'. Uncertain implementation date. Not likely to be adopted by the EU until the IASB has finished the rest of its financial instruments project.

iii) IFRS 10 – Consolidated Financial Statements
This builds on existing principles by identifying the concept of control as the determining factor in whether an entity should be included within the consolidated financial statements of the parent company and provides quidance to assist in the determination of control. Effective date of 2013/14 but not yet adopted by the EU.

iv) IFRS 11 – Joint Arrangements
This provides for a more realistic reflection of joint arrangements by focussing on the rights and obligations of the arrangements, rather than its legal form. It also requires a single method of accounting for interests in jointly controlled entities as such ensures consistency of reporting of joint arrangements. Effective date of 2013/14 but not yet adopted by the EU.

v) IFRS 12 – Disclosure of Interests in Other Entities
This is a new and comprehensive standard on disclosure requirements for all forms of interests in other entities, including joint arrangements, associates, special purpose vehicles and other off balance sheet vehicles. Effective date of 2013/14 but not yet adopted by the EU.

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

vii) IAS 1 – Presentation of Financial Statements, on Other Comprehensive Income (OCI)
This provides amendments that will improve and align the presentation of items of other comprehensive income (OCI) in financial statements prepared in accordance with IFRS and those prepared in accordance with US GAAP. This amendment requires some items in OCI in IFRS statements to be reclassified to the P&L section of the income statement. Effective date of 2013/14 but not yet adopted by the EU.

viii) IAS 12 – Income Taxes Amendment
The objectives of IAS 12 are to specify the accounting for current and deferred tax. Effective date of 2013/14 but not yet adopted by the EU.

ix) IAS 27 – Separate Financial Statements
This provides the requirement for preparing and presenting consolidated financial statements for a group of entities under the control of a parent and for presenting separate (non-consolidated) financial statements for investments in subsidiaries, jointly controlled entities and associates. Effective date of 2013/14 but not yet adopted by the EU.

x) IAS 28 – Associates and Joint Ventures
This amended version prescribes the accounting for investments in associates and sets out the requirements for the application of the equity method when accounting for investments in associates and joint ventures. The main change here is that the use of the equity method is now extended to joint arrangements with the proportionate consolidation method eliminated. Effective date of 2013/14 but not yet adopted by the EU.

xi) IAS 19 (revised 2011) – Employee Benefits
This amended version describes the approach to accounting for pension and termination costs. Effective date of 2013/14.

xii) IAS 32 Financial Instruments: Presentation – amendment
Offsetting financial assets and liabilities. This standard describes the presentation of offsetting financial assets and liabilities. Effective date of 2014/15 but not yet adopted by the EU.

1.20 Critical accounting estimates and assumptions

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

Value of land, buildings and dwellings £21,114,000 (2011/12 £25,455,000) – 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 14.1.

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 2012/13 financial year end, the estimated value of partially completed spells is £33,000 (2011/12 £36,000).

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 16.

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 18.

1.21 Operating segments

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

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

Reconstructive surgery is the trust's principal activity. Its other activities do not, individually, constitute 10% of revenue and have been agregated. There are therefore two reportable segments.

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

2. Operating segments

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

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

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

The financial results for each segment were as follows:

	2012/13		2011/12	
	Income £000	**Expenditure £000**	**Income £000**	**Expenditure £000**
Reconstructive surgery	48,978	35,373	47,539	35,390
All other segments	9,330	4,244	8,237	4,433
Total of reportable segments	**58,308**	**39,617**	**55,776**	**39,823**
Corporate services (see note below)		11,742		10,647
Depreciation and amortisation		1,786		1,796
(Reversal of) Impairment of property, plant and equipment		(1,648)		1,765
Restructuring costs		113		210
Finance income		–		(16)
Finance expense – unwinding of discount on provisions		–		16
PDC dividends payable		935		861
Surplus/(deficit) for the year		**5,763**		**674**

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

3. Income from patient care activities

	2012/13 £000	2011/12 £000
NHS foundation trusts	**–**	318
NHS trusts	**–**	136
Primary care trusts	**53,243**	51,623
Strategic health authorities	**45**	–
Non-NHS:		
Private patients	**142**	102
Injury costs recovery	**266**	386
Other	**–**	15
	53,696	52,580

'Injury costs recovery' is income received from insurance companies for the treatment of patients who have been involved in road traffic accidents. It is subject to a provision for impairment of receivables of 16.5% to reflect expected rates of collection.

Mandatory and non-mandatory services

Mandatory services are those which provide for the healthcare of NHS patients. All other services are non-mandatory. Of the total income reported above, £53,554,000, (2011/12 £52,478,000) was derived from the provision of mandatory services.

Private patient income

Until 1 October 2012 every NHS foundation trust was subject to an individually set limit on the amount of income it could derive from the treatment of private patients. From 1 October 2012, as a result of the Health and Social Care Act 2012, these limits were replaced by the requirement that income from the provision of goods and services for the NHS should not be less than that earned from other sources.

4. Other operating income

	2012/13 £000	2011/12 £000
Education, training and research	**1,516**	1,656
Charitable and other contributions to expenditure	**191**	111
Non-patient care services to other bodies	**1,643**	–
Reversal of impairments	**2,848**	–
Other income	**1,373**	1,540
	7,571	**3,307**

5. Operating expenses

	2012/13 £000	2011/12 £000
Services from NHS foundation trusts	**72**	1,840
Services from NHS trusts	**–**	2,571
Services from PCTs	**–**	33
Services from other NHS bodies	**–**	180
Purchase of healthcare from non-NHS bodies	**141**	6
Executive directors' costs	**422**	436
Non-executive directors' costs	**113**	117
Staff costs	**35,754**	35,202
Consultancy	**187**	–
Drugs	**1,117**	1,024
Supplies and services – clinical (excluding drugs)	**8,554**	4,586
Supplies and services – general	**557**	13
Establishment	**932**	1,610
Transport	**417**	173
Premises	**1,935**	1,476
Provision for impairment of receivables	**(313)**	218
Depreciation	**1,707**	1,796
Amortisation	**79**	24
Audit fees – statutory audit	**52**	57
Other auditor's remuneration – other services	**7**	7
Clinical negligence	**493**	435
Restructuring costs – pay	**126**	345
Restructuring costs – non-pay	**–**	143
Loss on disposal of buildings	**–**	65
Other	**941**	222
	53,293	**52,579**
Impairments of property, plant and equipment	**1,197**	1,765
	54,490	**54,344**

Notes:

Variances between years – At the beginning of 2012/13 a new accounting system was introduced, incorporating revised definitions of services from NHS bodies and the more general supplies and services categories. The significant year-on-year variances shown above result mainly from this redistribution of expenditure rather than any actual changes in the activities of the trust.

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

6. Operating leases

As lessee

Operating leases relate to buildings, heating systems, medical equipment and vehicles. Buildings are leased for periods of five or ten years. Medical equipment and vehicles are leased for periods of between two and five years.

Payments recognised as an expense	2012/13 £000	2011/12 £000
Minimum lease payments	**516**	296

Total future minimum lease payments	2012/13 £000	2011/12 £000
Payable:		
Not later than 1 year	**356**	463
Between 1 and 5 years	**1,025**	1,283
After 5 years	**423**	426
Total	**1,804**	2,172

7. Employee benefits and staff numbers

7.1 Employee benefits	2012/13 £000	2011/12 £000
Salaries and wages	**30.084**	29,005
Social security costs	**2,579**	2,522
Employer contributions to NHS Pension Scheme	**3,423**	3,367
Agency/contract staff	**755**	1,089
Employee benefits expense	**36,841**	35,983
Non-executive directors' benefits not included above	**113**	117
Total	**36,954**	36,100

7.2 Average number of people employed	2012/13 Number	2011/12 Number
Medical and dental	**123**	124
Administration and estates	**206**	200
Healthcare assistants and other support staff	**118**	120
Nursing, midwifery and health visiting staff	**181**	184
Scientific, therapeutic and technical staff	**137**	137
Bank and agency staff	**50**	66
Total	**815**	831

7.3 Directors' remuneration

Total remuneration paid to directors for the year ended 31/03/2013 (in their capacity as directors) totalled £535,000 (2011/12 £553,000). No other remuneration was paid to directors in their capacity as directors. There were no advances or guarantees entered into on behalf of directors by the trust. Employer contributions to the NHS Pension Scheme for executive directors for the year ended 31/03/2013 totalled £47,000 (2011/12 £49,000). The total number of directors to whom benefits are accruing under the NHS defined benefit scheme (the NHS Pension Scheme) was three.

7.4 Staff exit packages for staff leaving in 2012/13

Staff exit packages are payable when the trust terminates the employment of an employee before the normal retirement date or whenever an employee accepts voluntary redundancy in return for these benefits. During the year there were three such cases. The cost of these packages fell within the following bands:

Exit package cost band	**2012/13**		2011/12	
£000	**Number of compulsory redundancies**	**Total exit packages by cost band**	Number of compulsory redundancies	Total exit packages by cost band
10–25	**–**	**–**	3	8
25–50	**3**	**3**	1	1
50–100	**–**	**–**	2	2
Total	**3**	**3**	6	11

8. Retirements due to ill-health

During the year there were no early retirements due to ill health (2011/12, none).

9. Finance revenue

	2012/13 £000	2011/12 £000
Interest revenue from bank accounts	**20**	16

10. Intangible assets

Software licences	**2012/13 £000**	2011/12 £000
Gross cost at 1 April 2012	**281**	229
Additions	**579**	52
Disposals	**(42)**	–
Gross cost at 31 March 2013	**818**	281
Amortisation at 1 April 2012	**188**	164
Provided during the year	**79**	24
Disposals	**(42)**	–
Amortisation at 31 March 2013	**225**	188
Net book value		
Purchased assets at 1 April 2012	**93**	65
Purchased assets at 31 March 2013	**593**	93

11. Property, plant and equipment

11.1 Property, plant and equipment at 31 March 2013	Land £000	Buildings £000	Assets under construction £000	Plant and machinery £000	Information technology £000	Total £000
Cost or valuation at 1 April 2012	9,513	15,942	2,131	9,938	2,357	**39,881**
Additions – purchased	–	508	7,610	328	110	**8,556**
Additions – donated	–	–	29	101	–	**130**
Reclassifications	–	(194)	(540)	–	92	**(642)**
Impairments recognised in operating expenses	**(518)**	(679)	–	–	–	**(1,197)**
Reversal of impairments	–	2,848	–	–	–	**2,848**
Impairments recognised in revaluation reserve	(5,375)	(1,012)	–	–	–	**(6,387)**
Revaluation	–	81	–	–	–	**81**
Disposals	–	–	–	(864)	(728)	**(1,592)**
At 31 March 2013	**3,620**	**17,494**	**9,230**	**9,503**	**1,831**	**41,678**
Depreciation at 1 April 2012	–	–	–	7,392	1,783	**9,175**
Provided during the year	–	–	–	843	222	**1,065**
Revaluation gain/(loss)	–	–	–	–	–	**–**
Disposals	–	–	–	(864)	(728)	**(1,592)**
Depreciation at 31 March 2013	**–**	**–**	**–**	**7,371**	**1,277**	**8,648**
Net book value						
Purchased assets as at 1 April 2012	9,513	14,213	2,131	2,325	569	**28,751**
Donated assets as at 1 April 2012	–	1,729	–	221	5	**1,955**
Total at 1 April 2012	**9,513**	**15,942**	**2,131**	**2,546**	**574**	**30,706**
Purchased assets as at 31 March 2013	3,620	13,030	9,201	1,893	552	**28,296**
Donated assets as at 31 March 2013	–	4,464	29	239	2	**4,734**
Total at 31 March 2013	**3,620**	**17,494**	**9,230**	**2,132**	**554**	**33,030**

2011/12 comparators overleaf

11.1 Property, plant and equipment (continued)						
2011-12 comparators	Land	Buildings	Assets under construction	Plant and machinery	Information technology	**Total**
	£000	£000	£000	£000	£000	**£000**
Cost or valuation at 1 April 2011	9,513	15,190	915	10,141	2,502	**38,261**
Additions – purchased	–	3,832	1,608	600	88	**6,128**
Additions – donated	–	94	–	52	–	**146**
Reclassifications	–	(1,313)	(392)	(855)	(233)	**(2,793)**
Impairments recognised in operating expenses	–	(1,765)	–	–	–	**(1,765)**
Impairments recognised in revaluation reserve	–	(708)	–	–	–	**(708)**
Revaluation gain/(loss)	–	741	–	–	–	**741**
Disposals	–	(129)	–	–	–	**(129)**
At 31 March 2012	**9,513**	**15,942**	**2,131**	**9,938**	**2,357**	**39,881**
Depreciation at 1 April 2011	–	1,101	–	7,335	1,800	**10,236**
Provided during the year	–	676	–	904	216	**1,796**
Reclassifications	–	(1,713)	–	(847)	(233)	**(2,793)**
Disposals	–	(64)	–	–	–	**(64)**
Depreciation at 31 March 2012	**0**	**0**	**0**	**7,392**	**1,783**	**9,175**
Net book value						
Purchased assets as at 1 April 2011	9,513	12,486	915	2,532	700	**26,146**
Donated assets as at 1 April 2011	–	1,603	–	274	2	**1,879**
Total at 1 April 2011	**9,513**	**14,089**	**915**	**2,806**	**702**	**28,025**
Purchased assets as at 31 March 2012	9,513	14,213	2,131	2,325	569	**28,751**
Donated assets as at 31 March 2012	–	1,729	–	221	5	**1,955**
Total at 31 March 2012	**9,513**	**15,942**	**2,131**	**2,546**	**574**	**30,706**

11.2 Protected and non-protected property, plant and equipment

The net book values disclosed above relate entirely to protected assets with the exception of non-protected land valued at £687,000 at 31 March 2013 (£1,807,000 at 31 March 2012), which is included within the totals.

11.3 Fully depreciated assets

Fully depreciated assets with an aggregate gross carrying value of £4,311,000 are still in use.

11.4 Property, plant and equipment donated during the year

During the year, medical equipment with a value of £112,000 was donated to the trust by the Queen Victoria Hospital NHS Trust Charitable Fund.

12. Capital commitments

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

	31 March 2013 £000	31 March 2012 £000
Property, plant and equipment	**2,450**	8,501

The decrease in capital comitments reflects the progress towards completion of the operating theatres new build which was committed but only recently commenced as at 31 March 2012.

13. Inventories

Inventories at 31 March	31 March 2013 £000	31 March 2012 £000
Drugs	**100**	90
Clinical consumables	**288**	206
Other	**2**	8
Total	**390**	**304**

14. Trade and other receivables

14.1 Trade and other receivables comprise:	31 March 2013	31 March 2012
	Current £000	Current £000
NHS and other related party receivables	**2,745**	1,649
Other trade receivables	**776**	1,292
Accrued income	**116**	36
Provision for the impairment of receivables	**(724)**	(1,130)
Prepayments	**331**	376
Other receivables	**290**	-
Total	**3,534**	2,223

The great majority of trade was with primary care trusts, as commissioners for NHS patient care services. As primary care trusts were funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

14.2 Receivables past their due date but not impaired	31 March 2013 £000	31 March 2012 £000
By up to three months	**1,471**	23
By between three and six months	**213**	229
By more than six months	**264**	639
Total	**1,948**	891

14.3 Provision for impairment of NHS receivables	31 March 2013 £000	31 March 2012 £000
Balance at 1 April 2012	**(1,104)**	(861)
Amount recovered or written off during the year	**637**	–
Increase in receivables impaired	**(245)**	(243)
Balance at 31 March 2013	**(712)**	(1,104)

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.

14.4 Provision for impairment of non-NHS receivables	31 March 2013 £000	31 March 2012 £000
Balance at 1 April 2012	**(26)**	(51)
Amount recovered or written off during the year	**11**	25
Increase in receivables impaired	**(13)**	–
Balance at 31 March 2013	**(28)**	(26)

15. Cash and cash equivalents

	31 March 2013 £000	31 March 2012 £000
Balance at 1 April 2012	**5,979**	6,967
Net change in year	**2,158**	(988)
Balance at 31 March 2013	**8,137**	5,979
Comprising:		
Cash with the Government Banking Service (GBS)	**8,075**	6,384
Commercial banks and cash in hand	**62**	(405)
Cash and cash equivalents as in statement of cash flows	**8,137**	5,979

The negative balance with commercial banks represented cash in transit. It was covered by a transfer from the GBS account before the cash left the commercial account.

16. Trade and other payables

	31 March 2013 £000	31 March 2012 £000
NHS payables	**578**	645
Trade payables – capital	**1,307**	334
Other payables – revenue	**1,343**	712
Accruals	**1,129**	1,016
	4,357	2,707
Tax and social security costs	**812**	769
Total	**5,169**	3,476

NHS payables include £469,000 outstanding pensions contributions at 31 March 2013 (31 March 2012 £424,000).

17. Deferred income

	31 March 2013 £000	31 March 2012 £000
Total	**129**	495

18. Provisions

Current	31 March 2013 £000	31 March 2012 £000
Pensions relating to staff	**26**	26
Legal claims	**1**	3
Total	**27**	29

Non-current	31 March 2013 £000	31 March 2012 £000
Pensions relating to staff	**522**	465

Movements in-year	Pensions relating to staff £000	Legal claims £000	Total £000
At 1 April 2012	**491**	**3**	**494**
Change in discount rate	**35**	**–**	**35**
Arising during the year	**33**	**–**	**33**
Used during the year	**(26)**	**(2)**	**(28)**
Reversed unused	**–**	**–**	**–**
Unwinding of discount	**15**	**–**	**15**
At 31 March 2013	**548**	**1**	**549**
Expected timing of cash flows:			
Within one year	**26**	**1**	**27**
Between one and five years	**99**	**–**	**99**
After five years	**423**	**–**	**423**
	548	**1**	**549**

The provision for pensions relating to staff comprises £490,000 in respect of injury benefit (31/3/2012 – £434,000) and £58,000 in respect of early retirements (31/3/2012 – £57,000). The amounts represent the discounted future value of annual payments made to the NHS Pensions Agency calculated on an actuarial basis.

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

£2,541,000 was included in the provisions of the NHS Litigation Authority at 31/3/2013 in respect of clinical negligence liabilities of the trust (31/3/2012 £2,135,000).

19. Finance expense

Interest expense	31 March 2013 £000	31 March 2012 £000
Loans from the Foundation Trust Financing Facility	**84**	–

20. 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.

20.1 Financial assets and liabilities by category

All financial assets and liabilities are denominated in sterling.

Financial assets	31 March 2013 Loans and receivables £000	31 March 2012 Loans and receivables £000
NHS and other related party receivables	**2,215**	1,022
Accrued income	**116**	36
Other receivables	**878**	1,292
Cash at bank and in hand	**8,137**	5,979
Total	**11,346**	8,329

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 2013 Carrying value £000	31 March 2012 Carrying value £000
Borrowings	**6,500**	1,000
Trade and other payables	**3,228**	1,607
Accrued expenditure	**1,129**	1,016
Total	**10,857**	3,623

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

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

Other tax and social security cost amounts of £812,000 (2011/12 £768,000) and deferred income of £129,000 (2011/12 £495,000) are not classed as financial instruments and have therefore been excluded from the above analysis.

20.2 Maturity of financial assets

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

20.3 Maturity of financial liabilities

All of the trust's financial liabilities fall due within one year with the exception of the £6,250,000 portion of the borrowings that falls due after more than one year.

20.4 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.

20.5 Financial risk management

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

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

Currency risk

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

Credit risk

Because the majority of the trust's income comes from contracts with other public sector bodies, the trust has low exposure to credit risk. The maximum exposures as at 31 March 2013 are in receivables from customers, as disclosed in note 18.

Liquidity risk

The trust's operating costs are incurred under contracts with clinical commissioning groups, which are financed from resources voted annually by Parliament. The trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The trust is not, therefore, exposed to significant liquidity risks.

21. Prudential borrowing limit

The NHS foundation trust is required to comply and remain within a prudential borrowing limit (PBL). This is made up of two elements:

1 The maximum cumulative amount of long term borrowing. This is set by reference to the four ratio tests set out in the *Prudential Borrowing Code for NHS foundation trusts*; and

2 The amount of working capital approved by Monitor.

Further information on the *Prudential Borrowing Code for NHS foundation trusts* and *Compliance Framework* can be found on Monitor's website.

The limits and ratios in respect of the trust are as follows:

	At 31 March 2013 £000	At 31 March 2012 £000
The prudential borrowing limit is the sum of:		
Maximum cumulative long term borrowing limit	**10,600**	12,000
Approved working capital facility, not exceeding	**4,000**	4,000

The trust had drawn down £NIL of its working capital facility at 31 March 2013 (£NIL 2011/12).

Long term borrowing	At 31 March 2013 £000	At 31 March 2012 £000
Net actual borrowing in year long term	**5,500**	1,000
Total borrowing against PBL	**6,500**	1,000

Financial ratio	Approved PBL		
	Actual ratios 2012/13	Actual ratios 2011/12	**Test ratios**
Minimum dividend cover	**7.4**	**5.9**	>1x
Minimum interest cover	**40**	**126.5**	>3x
Minimum debt service cover	**10.4**	**126.5**	>2x
Maximum debt service to revenue	**0.1%**	**0.1%**	<2.5%

22. Related party transactions

No board members or members of the key management staff or parties related to them undertook any material transactions with Queen Victoria Hospital NHS Foundation Trust during 2012/13 (2011/12 none).

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

Goods and services were bought from and sold to McIndoe Surgical Centre Ltd, a private healthcare company many of whose shareholders are consultants employed by the trust and with which the trust has a profit-sharing agreement. A director of Queen Victoria Hospital NHS Foundation Trust is also chair of McIndoe Surgical Centre Ltd.

Other public sector bodies included within the Whole of Government Accounts are also deemed to be related parties. The trust has financial transactions with many such bodies.

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

	2012/13		2011/12	
Private sector and charitable organisations	**Income £000**	**Expenditure £000**	Income £000	Expenditure £000
The Queen Victoria Hospital NHS Trust Charitable Fund	191	–	90	–
McIndoe Surgical Centre	121	8	78	16
	312	**8**	168	16

	31 March 2013		31 March 2012	
	Receivables £000	**Payables £000**	Receivables £000	Payables £000
The Queen Victoria Hospital NHS Trust Charitable Fund	–	1	–	–
McIndoe Surgical Centre	30	–	23	–
	30	**1**	23	–

Whole of Government Accounts bodies	**2012/13**		2011/12	
Bodies with whom either income or expenditure exceeded £150,000 during the year:	**Income £000**	**Expenditure £000**	Income £000	Expenditure £000
Income and expenditure				
West Sussex PCT	**21,114**	**-**	20,732	36
West Kent PCT	**11,924**	**-**	11,509	(43)
Surrey PCT	**5,016**	**-**	4,881	16
Medway PCT	**4,356**	**-**	4,142	11
Eastern and Coastal Kent PCT	**4,283**	**-**	4,245	-
Croydon PCT	**3,605**	**-**	3,140	-
Brighton and Sussex University Hospitals NHS Trust	**1,713**	**818**	1,752	291
Bromley PCT	**939**	**-**	818	-
Bexley NHS Care Trust	**938**	**-**	907	-
Guy's And St. Thomas' NHS Foundation Trust	**254**	**32**	306	30
Hampshire PCT	**236**	**-**	194	-
Maidstone and Tunbridge Wells NHS Trust	**162**	**33**	135	534
Greenwich Teaching PCT	**150**	**-**	222	-
Dartford and Gravesham NHS Trust	**1**	**860**	7	768
Medway NHS Foundation Trust	**-**	**850**	1	1,019
East Sussex Hospitals NHS Trust	**85**	**728**	145	704
NHS Litigation Authority	**-**	**495**	-	435
South East Coast Ambulance Service NHS Foundation Trust	**1**	**251**	2	468
NHS Blood and Transplant	**-**	**156**	-	155
Other	**2,021**	**873**	1,584	675
	56,798	**5,096**	54,722	5,099

	31 March 2013		31 March 2012	
Receivables and payables	**Receivables £000**	**Payables £000**	Receivables £000	Payables £000
West Sussex PCT	**1,003**	**–**	24	36
West Kent PCT	**118**	**–**	125	–
Surrey PCT	**9**	**–**	41	–
Medway PCT	**11**	**–**	94	–
Eastern and Coastal Kent PCT	**6**	**–**	–	–
Croydon PCT	**190**	**–**	236	–
Brighton and Sussex University Hospitals NHS Trust	**272**	**109**	271	30
Bromley PCT	**–**	**–**	12	99
Bexley NHS Care Trust	**81**	**–**	85	–
Guy's And St. Thomas' NHS Foundation Trust	**237**	**5**	293	–
Hampshire PCT	**30**	**–**	–	3
Maidstone and Tunbridge Wells NHS Trust	**61**	**11**	94	25
Greenwich Teaching PCT	**90**	**–**	97	–
Dartford and Gravesham NHS Trust	**1**	**–**	1	2
Medway NHS Foundation Trust	**–**	**23**	1	17
East Sussex Hospitals NHS Trust	**108**	**67**	91	67
NHS Litigation Authority	**–**	**2**	–	–
South East Coast Ambulance Service NHS Foundation Trust	**1**	**231**	1	36
NHS Blood and Transplant	**–**	**2**	–	5
Other	**810**	**598**	650	538
	3,028	**1,048**	2,116	858

23. Intra-government and other balances

At 31 March 2013	**Receivables: amounts falling due within one year £000**	**Payables: amounts falling due within one year £000**
Balances with NHS bodies	**2,810**	578
Balances with other government bodies	**218**	1,282
Balances with bodies external to government	**506**	3,309
	3,534	**5,169**

At 31 March 2012	**Receivables: amounts falling due within one year £000**	**Payables: amounts falling due within one year £000**
Balances with NHS bodies	1,577	221
Balances with other government bodies	72	–
Balances with bodies external to government	574	3,255
	2,223	**3,476**

24. Losses and special payments

Losses and special payments are calculated on an accruals basis.

There were 18 cases of losses and special payments totalling £91,000 approved during 2012/13, (16 cases totalling £5,000 in 2011/12).

There were no fraud cases.

25. Financial risk rating*

Monitor, the independent regulator of NHS foundation trusts, assigns a risk rating on a scale of 1 to 5 to each foundation trust. A rating of 1 reflects the highest level of risk and 5 the lowest. The rating is based on a basket of financial ratios, each of which has its own weighting. Ratios based on earnings before interest, tax, depreciation and amortisation (EBITDA) are calculated after excluding impairments and restructuring costs. In 2012/13 the trust achieved an overall rating of 5 (subject to confirmation by Monitor), (2011/12, 5).

For the purposes of the risk rating, retained surplus is calculated as follows:

	2012/13 £000	2011/12 £000
Surplus from statement of comprehensive income	**5,763**	674
Add back:		
Impairments of property, plant and equipment	**1,197**	1,765
Reversal of impairments	**(2,848)**	–
Restructuring costs	**113**	488
Surplus for risk rating	**4,225**	2,927

* This note has not been subject to audit.

26. Third party assets

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

Annexes 7

Annex A: 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 on-going 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 2013 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

The director of nursing and quality is the trust's lead for risk, supported by the patient safety and governance manager (head of risk).

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

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

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

The risk and control framework

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

- look for the hazards
- decide who / what might be affected and how
- evaluate the risks and decide whether existing precautions (controls) are adequate or more should be done (actions)
- record and communicate the findings
- review.

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

Identified risks are classed as departmental or corporate. Departmental risks are low level risks managed within departments to ensure staff are aware of potential hazards within their working practice. Corporate risks may be from escalated departmental concerns or are risks affecting the whole trust requiring input and monitoring from directorates and senior committees. The trust risk appetite is based on the level of risk and the authority a manager or committee has in managing it. High level risks (major and catastrophic rated 16-25) will be escalated to directorate level and reviewed by the directorates, quality and risk committee and trust board. If adequate controls cannot be put in place to treat the risk a decision will be made to terminate, transfer or accept the risk.

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

- patient safety
- staff safety
- estates infrastructure and environment
- information governance
- compliance (targets, assessments, standards)
- finance.

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

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

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

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

The trust board also gets its assurances from the internal auditors, external auditors, independent review bodies and audit committee. The audit committee has reviewed the trust's management of risk which is undertaken through the quality and risk committee.

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

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

In respect of maintaining registration with the CQC's Essential Standards of Quality and Safety, a robust assessment of compliance against the 28 outcomes has been undertaken and systems and processes are in place to provide management and board assurance. An executive lead is assigned to each outcome and the risk management software records evidence of compliance. The risk team monitor the process and any potential identified weakness is addressed and assigned to an individual as an action. The quality and risk committee reviews outstanding actions and the CQC quality and risk profile on a quarterly basis to ensure processes are in place to address areas of reduced compliance.

The foundation trust is fully compliant with the CQC registration requirements. In 2012/13 the trust participated in a routine CQC inspection relating to the following areas:

- Outcome 2: Consent to care and treatment
- Outcome 4: Care and welfare of people who use services
- Outcome 7: Safeguarding people who use services from abuse
- Outcome 12:Requirements relating to workers
- Outcome 16: Assessing and monitoring the quality of service provision
- Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential.

For Outcome 21 minor concerns were raised and QVH is taking action to address the conclusions reported by the CQC in regard to documentation within health records.

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

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

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

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

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

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

We have a robust business planning process that involves comprehensive meetings with the clinical directorates to determine the business plans for the coming year. For 2012/13 the emphasis continued to focus on the planning of clinical activity and the establishment of the activity plans for the next three years and the process developed further the clinical input to planning at service line level.

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

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

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

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

Annual quality report

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

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

- Quarterly updates to the quality and risk committee on progress against priorities identified in the 2011/12 quality accounts.
- Monthly updates to clinical cabinet and the board of directors on metrics (including MRSA, cancer 62 days and 18 weeks referral to treatment targets).
- The clinical outcomes group receiving specialty information/ audit and national audit outcome data.
- External audit of systems and processes for data collection.

Review of effectiveness

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

Conclusion

The trust has continued to face significant challenges in 2012/13 and, despite on-going pressures, has continued to achieve excellent operational and financial performance in the year. The review of governance and controls confirms that the trust has managed risks effectively through the year and can provide assurance that effective systems are in place to support the running of the organisation. I am pleased to conclude that at the end of the year there are no significant internal control issues for the trust.

Amanda Parker
Director of Nursing and Quality
28 May 2013

Annex B: Performance against national targets

National priority indicators	Measure	Target	2012/13	
Clostridium difficile infections	Count	≤5	0	Green
MRSA bacteraemia	Count	≤1	2	Green
Cancer: 2 week wait from urgent GP referral to date first seen	%	93%	95%	Green
Cancer: 31 day wait from diagnosis to first treatment	%	96%	97%	Green
Cancer: 31 day wait for second or subsequent treatment - surgery	%	94%	97%	Green
Cancer: 62 day wait from urgent GP referral to treatment	%	85%	94%	Green
Attendees seen within 4 hours in minor injuries unit	%	95%	99%	Green
Time to initial assessment for ambulance patients	95th percentile	≤15 mins	0	Green
Time to treatment decision (median)	Median	≤60 mins	27	Green
Left without being treated	%	≤5%	0.2%	Green
18 week referral to treatment - admitted	%	90%	91%	Green
18 week referral to treatment - non-admitted	%	95%	97%	Green
18 week referral to treatment - incomplete pathways	%	92%	94%	Green
Receving diagnostic test within 6 weeks	%	99%	98%	Amber
Cancellations on the day of operation	Count	N/A	23	Green
Delayed transfers of care (acute only)	Count	N/A	12	Green
Same-sex accommodation breaches	Count	N/A	0	Green

Annex C: Remuneration report

Salary and pension entitlements of senior managers								
A. Remuneration	**1 April 2012 to 31 March 2013**				**1 April 2011 to 31 March 2012**			
Name and title	**Salary**	**Performance-related bonus**	**Other remuneration**	**Benefits in kind**	**Salary**	**Performance-related bonus**	**Other remuneration**	**Benefits in kind**
	(Bands of £5,000) £000	(Bands of £5,000) £000	(Bands of £5,000) £000	Rounded to the nearest £100	(Bands of £5,000) £000	(Bands of £5,000) £000	(Bands of £5,000) £000	Rounded to the nearest £100
P Griffiths Chairman	40-45	0	0	700 home to base and car usage	40-45	0	0	100 car usage
J Beech Non-Executive Director	10-15	0	0	200 car usage	10-15	0	0	600 home to base and car usage
R Leach Non-Executive Director	10-15	0	0	100 car usage	10-15	0	0	0
H Ure Non-Executive Director	n/a	n/a	n/a	n/a	5-10	0	0	600 home to base and car usage
S Winning Non-Executive Director	10-15	0	0	0	10-15	0	0	4500 home to base
A Bull Chief Executive	140-145	0	0	100 car usage	140-145	0	0	200 car usage
K Lavery Medical Director	10-15	0	105-110	400 car usage	10-15	45-50	135-140	0
R Hathaway Director of Finance and Commerce	100-105	0	0	0	100-105	0	0	0
A Parker Director of Nursing and Quality	90-95	0	0	100 car usage	90-95	0	0	0
L Porter Non-Executive Director	10-15	0	0	0	5-10	0	0	0

No performance related bonus was paid in 2012/13.

H Ure left the trust 30 September 2011.

The median remuneration of all the trust's staff is £27,499.

The ratio of the mid-point of the banded remuneration of the highest paid director to the median is 5.2:1.

Salary and pension entitlements of senior managers							
B. Pension benefits							
Name and title	**Real increase in pension at age 60**	**Lump sum at age 60 related to real increase in pension**	**Total accrued pension at age 60 at 31 March 2013**	**Lump sum at age 60 related to accrued pension at 31 March 2013**	**Cash equivalent transfer value at 31 March 2013**	**Cash equivalent transfer value at 31 March 2012**	**Real increase in cash equivalent transfer value**
	(Bands of £2,500) £000	(Bands of £2,500) £000	(Bands of £5,000) £000	(Bands of £5,000) £000	£000	£000	£000
A Bull Chief Executive	0-2.5	5-7.5	20-25	65-70	464	416	27
R Hathaway Director of Finance and Commerce	0-2.5	2.5-5	25-30	85-90	474	438	13
A Parker Director of Nursing and Quality	0-2.5	2.5-5	25-30	85-90	521	486	10

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.

Real increase in CETV – this 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.

Note: K Lavery reached normal retirement age during 2011/12. Therefore there are no entries in respect of pension.

Annex D: Board of directors register

Name, title and appointment	Meeting attendance and role 2011/12					
	Board of directors	**Council of governors**	**Audit committee**	**Charitable funds advisory committee**	**Nomination and remuneration committee**	**Quality and risk committee**
Peter Griffiths Chairman 1 April 2005 to 31 March 2015	11 of 11 Chairman	3 of 4 Chairman	– –	– –	4 of 4 Chairman	– –
Jeremy Beech Non-Executive Director 1 October 2005 to 30 Sept 2013	11 of 11 Member	3 of 4 Attendee	– –	– –	3 of 4 Member	4 of 4 Chairman
Renny Leach Non-Executive Director Senior Independent Director 1 January 2007 to 30 Sept 2014	11 of 11 Member	4 of 4 Attendee	5 of 5 Member	4 of 4 Chairman	4 of 4 Member	– –
Lester Porter Non-Executive Director 1 Sept 2011 to 31 August 2014	11 of 11 Member	3 of 4 Attendee	– –	3 of 4 Member	4 of 4 Member	4 of 4 Member
Shena Winning Non-Executive Director 1 October 2005 to 30 Sept 2013	10 of 11 Member	3 of 4 Attendee	5 of 5 Chairman	4 of 4 Member	4 of 4 Member	– –
Adrian Bull Chief Executive December 2008 to 31 March 2013	10 of 11 Member	4 of 4 Attendee	1 of 5 In attendance as required	– –	4 of 4 Member	3 of 4 Member
Ken Lavery Medical Director November 2007 to 31 March 2013	9 of 11 Member	4 of 4 Attendee	– –	2 of 4 Member	– –	2 of 4 Member
Richard Hathaway Director of Finance and Commerce April 2010 to present	10 of 11 Member	4 of 4 Attendee	5 of 5 In attendance as required	3 of 4 Member	– –	4 of 4 Member
Amanda Parker Director of Nursing and Quality August 2009 to present	10 of 11 Member	4 of 4 Attendee	4 of 5 In attendance as required	– –	– –	4 of 4 Member

Annex E: Council of governors register

Governor	Constituency	Term	Meeting attendance
Brian Beesley****	Public	Elected 2011 to 2014	4 of 4
Edward Belsey	Public	Re-elected 2009 to 2012	1 of 1
John Bowers	Public	Re-elected 2011 to 2012	1 of 1
Patricia Brigden	Public	Elected 2010 to 2013. *Resigned May 2012*	0 of 1
Howard Bloom	Stakeholder (West Sussex County Council)	Appointed 2012 to 2015	2 of 4
Mabel Cunningham	Staff	Re-elected 2011 to 2014	4 of 4
Jenny Cunnington	Public	Elected 2011 to 2014	4 of 4
John Dabell	Public	Elected 2011 to 2014	3 of 4
Brian Goode*	Public	Elected 2010 to 2013	4 of 4
Robin Graham	Public	Elected 2011 to 2014	4 of 4
Michael Hannah	Public	Elected 2011 to 2014	2 of 4
John Harold	Public	Elected 2012 to 2015	3 of 3
Anne Higgins	Public	Elected 2011 to 2014	2 of 4
Valerie King	Public	Re-elected 2011 to 2014	4 of 4
Carol Lehan	Staff	Re-elected 2011 to 2014	3 of 4
Moira McMillan***	Public	Elected 2010 to 2013	3 of 4
Christopher Orman	Public	Elected 2011 to 2014	4 of 4
Christian Petersen	Staff	Elected 2010 to 2013	3 of 4
Louise Reader	Staff	Elected 2012 to 2015	2 of 3
Andrew Robertson	Stakeholder (League of Friends)	Appointed 2010 to 2013	4 of 4
Gillian Santi	Public	Elected 2011 to 2014	3 of 4
Michael Shaw	Public	Elected 2011 to 2014	3 of 4
Manya Sheldon	Public	Re-elected 2009 to 2012	1 of 1
Ian Stewart**	Public	Re-elected 2011 to 2014	4 of 4
Jonathan Street	Public	Elected 2011 to 2014. *Resigned September 2012*	1 of 2
Alan Thomas	Public	Re-elected 2012 to 2015	4 of 4
Norman Webster	Stakeholder (East Grinstead Town Council)	Appointed 2011 to 2014	4 of 4
Janet Webster	Public	Elected 2012 to 2015. *Resigned October 2012*	0 of 1
Peter Wickenden	Public	Elected 2011 to 2014	3 of 4

Meeting attendance figures are provided for formal meetings of the council of governors held in public, not including the annual general meeting of the trust which was held on 19 July 2012. The last column shows attendance compared to the maximum number of meetings each governor was expected to attend within their individual terms of office.

* As governor representative to the board of directors, Brian Goode attended 10 of the 11 board meetings held in 2012/13.

** Ian Stewart is the vice chairman and lead governor.

*** As a governor representative to the quality and risk committee, Moira McMillan attended all four of the committee meetings held in 2012/13.

**** As public governor representative to the charitable funds advisory committee, Brian Beesley attended three of the four committee meetings held in 2012/13.

Annex F: Directors' biographies

Peter Griffiths, Chairman

Peter Griffiths has spent his entire career in healthcare.

His last executive appointments within the NHS were as Deputy Chief Executive for the Management Executive at the Department of Health and Chief Executive of the Guys & Lewisham first-wave NHS trust.

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

On appointment in 2005, he stepped down as Non-Executive Director of the Sussex Downs and Weald Primary Care Trust to become QVH Chairman.

Peter stepped down as chairman of the board of the Foundation Trust Network on 31 March 2013.

Dr Adrian Bull, Chief Executive

Adrian became Chief Executive of QVH on 15 December 2008.

Adrian served for six years as a medical officer in the Royal Navy, completing his training in general practice. On joining the NHS, he gained his MD in epidemiology and became a consultant in public health medicine, holding several senior medical and management positions in health authorities and NHS trusts.

In recent years, Adrian has worked in the private sector as Group Medical Director of PPP Healthcare, Managing Director of Carillion Health, and Commercial and Medical Director for Humana Europe.

Richard Hathaway, Director of Finance and Commerce

Richard is a chartered accountant and joined QVH from NHS South East Coast, the region's strategic health authority at that time.

He was Director of Finance at the Royal West Sussex NHS Trust for three years until 2009 and was previously the Director of Finance at Mid Sussex Primary Care Trust. He joined the NHS from an international accountancy practice in 1992.

In addition to financial management, Richard and his team are responsible for QVH's procurement and contracting, performance management, information and IT functions.

Mr Ken Lavery, Medical Director

Mr Ken Lavery, consultant in oral and maxillofacial surgery trained in dentistry and medicine at the University of Dundee. After qualifying he undertook post-graduate training in general surgery, plastic surgery, ENT and neurosurgery before commencing his specialist training as an oral and maxillofacial surgeon at QVH and Guy's Hospital.

Ken's specialty areas are the surgical aspects of head and neck oncology, reconstruction and salivary gland surgery. He has represented his specialty both regionally and nationally.

Ken was appointed QVH's Medical Director on 1 November 2007.

Amanda Parker, Director of Nursing and Quality

Amanda Parker was appointed Director of Nursing and Quality in August 2009, having previously held the post of Deputy Director of Nursing.

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

Amanda brings strong academic and operational experience to the role. She is a registered nurse teacher with an MA in nursing and education, has an MSc in surgical and perioperative care and served as Chair of the Education Committee on the Board of the Association for Perioperative Practice (AfPP).

Jeremy Beech CBE, Non-Executive Director

Jeremy Beech from Frittenden in Kent is a chartered engineer.

He spent over 30 years in the fire and rescue services occupying positions as Assistant Chief Fire Officer of the London Fire Brigade, Chief Fire Officer of Kent, and Chief Executive of the Kent and Medway Fire Authority. He also served for 12 years as one of the five UK members of the Channel Tunnel Safety Authority, and led for the UK on rescue, public safety and bi-national planning for emergencies.

Following his fire service career, Jeremy worked for the UK government in maritime counter terrorism, and also as an adviser to government committees and other bodies. He remains a consulting engineer. He served as Non-Executive Director of the Port of London Authority from 2003 to 2009, and Non-Executive Chairman of MKC Training Services Ltd, from 2008 to 2011. He is Vice Chairman of the Kent Foundation.

At QVH, Jeremy is chairman of the quality and risk committee.

Dr Renny Leach, Non-Executive Director and Senior Independent Director

Renny Leach is currently a board member of two biotechnology companies as well as a contract clinical research company. He is the medical research director for the children's medical research charity Sparks. Renny is a trustee of the Lord Snowdon Award scheme for disabled students and chairs the QVH charitable fund advisory committee. He lives in Forest Row.

Renny was previously Director of Clinical Research at the Institute of Child Health and Great Ormond Street Hospital for Children NHS Trust and has held senior positions within the UK Medical Research Council, the Horsham-based charity Action Medical Research and was CEO of a contract clinical research company.

At QVH, Renny is chairman of the charitable funds advisory committee.

Lester Porter, Non-Executive Director

Lester Porter was appointed a Non-Executive Director of QVH in September 2011.

He has been Chairman of the Thomas Cook Pension Trust since 2005 and has his own executive coaching practice working with individual executives and company boards. He also spent over ten years as an 'angel' investor in start-up businesses based in the south east and holds board positions with several of these companies.

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

Shena Winning, Non-Executive Director

Shena Winning from Elham, near Canterbury, is a chartered accountant. Formerly Finance Director of CarpetRight plc, she has over 20 years of experience within the retail sector.

Shena is Non-Executive Director of Nisa-Todays Ltd and Chadwick House Group Ltd and was Non-Executive Chairman of Swallowfield plc from March 2005 to April 2011 and Non-Executive Director of South East Kent Community Health Trust from July 1996 to January 1998.

At QVH, Shena is chairman of the audit committee.

Annex G: Disclosures

Statement of compliance with the NHS Foundation Trust Code of Governance

The board of directors of QVH confirms that the trust complies with the provisions of the NHS Foundation Trust Code of Governance.

Statement of disclosure to auditors

For each individual who is a director at the time the annual report is approved, so far as the directors are aware, there is no relevant audit information of which the NHS foundation trust's auditor is unaware; and the directors have taken all the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the NHS foundation trust's auditor is aware of that information. ("Relevant audit information" means information needed by the NHS foundation trust's auditor in connection with preparing their report.)

A director is regarded as having taken all the steps that they ought to have taken as a director in order to do the things mentioned above if he/she has:

- made such enquiries of his/her fellow directors and of the NHS foundation trust's auditors for that purpose; and
- taken such other steps (if any) for that purpose as are required;
- by his/her duty as a director of the NHS foundation trust to exercise reasonable care, skills and diligence.

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.

The accounts have been prepared under a direction from Monitor.

Accounting policies for pensions and other retirement benefits are set out in note 1.2 to the accounts and details of senior employees' remuneration can be found in annex C.

Policy and payment of creditors

The trust seeks to comply with the Better Payment Practice Code and pay all suppliers promptly.

Income disclosure

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. Queen Victoria Hospital NHS Foundation Trust has met this requirement for 2012/13.

Review of tax arrangements of public sector appointees

As of 31 January 2012 there were two off payroll arrangements in place at a cost of over £58,200 per annum. One of these arrangements has come to an end and the other has been extended to include contractual clauses that allow the department to seek assurance as to their tax obligations.

There were no new off-payroll arrangements between 23 August 2012 and 31 March 2013 for more than £220 per day and more than six months.

Employing disabled persons

QVH has a robust recruitment and selection policy which was updated in 2012/13 and a full equality and human rights impact analysis is available from our website. We use the guaranteed interview scheme for recruitment which identifies applicants with a disability using the facilities available on the NHS Jobs recruitment website and we remind managers to interview those applicants providing they meet the essential criteria for the role. Applicants with disabilities who require adjustments are also identified through this process.

Staff who become disabled are supported by their line managers, the occupational health service and, where appropriate, the access to work scheme to enable them to remain in their role. We arrange suitable adjustments where possible and did so for three members of staff during 2012/13 which included improving access to car parking and changing working hours. Redeployment to other roles is also considered with advice from our occupational health service and in line with the trust's sickness policy.

Delivery of training is under regular review as part of our equality objective scheme action plan and we work with disabled staff as individuals, discussing their needs on a case-by-case basis. The trust is in the process of re-accreditation as a 'two ticks' disability employer.

Information governance

Information governance (IG) provides the trust with a framework to assist the handling of information in a systematic way. Individuals must have confidence that their personal and sensitive information is safeguarded and used appropriately to help deliver the best possible standards of care. All staff are required to undertake information governance training on an annual basis.

The information governance agenda is supported by the IG Toolkit, a Department of Health online system which incorporates 45 assessment requirements for IG compliance across management, security, confidentiality, clinical information quality and corporate documentation standards. QVH submitted an overall score of 77% for its 2012/13 assessment, achieving a satisfactory rating across all requirements.

Staff are actively encouraged to report any information governance related incidents in line with the trust's incident reporting process.

The trust had no significant breaches of data security during 2012/13.

Information governance incidents 2012/13	
Type	Number
Misfiled documentation	27
Misplaced documentation	14
Documentation errors/incomplete documentation	22
Poor data quality	2
Unauthorised disclosure	1