NHS
Queen Victoria Hospital
NHS Foundation Trust

Annual Report, Quality Report and Accounts **2016/17**

Queen Victoria Hospital NHS Foundation Trust

Annual Report, Quality Report and Accounts 2016/17

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

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1

Introduction

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

1.1 Chair's introduction

I am pleased to present the 2016/17 annual report, quality report and accounts for Queen Victoria Hospital NHS Foundation Trust.

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

In 2016 the Care Quality Commission rated us as 'good' with 'outstanding' patient care and we are committed to working towards every aspect of QVH being rated as outstanding. Our values of humanity, pride and continuous improvement are at the centre of everything we do. With around 900 members of staff, an active council of governors and assisted by our band of volunteers, we have a great team here at QVH. They are critical to our continued success and I am confident that we have the expertise and ability to deliver outstanding patient experience and world class clinical services whilst remaining efficient and financially sustainable.

As part of the wider NHS, partnerships are particularly important for us. We work with other trusts and our local health community to ensure a full spectrum of care can be provided, as well as being an active contributor to our local sustainability and transformation programme addressing the longer term future of NHS services.

During 2016/17 we appointed a new chief executive and new medical director, who I am confident will continue to build on the reputation of QVH as a centre of excellence, providing the very best care to patients.

Those working at QVH are rightly proud of what they do, and I want to thank our volunteers, governors, staff and board members for their dedication and hard work. As we continue to work closely with partner organisations in the context of a changing NHS, I am confident we will continue to deliver pioneering treatments, a collaborative approach and outstanding patient care.

Beryl Hobson
Chair

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Performance report

"During 2016/17 Queen Victoria Hospital has continued to strive for the delivery of targets for timely treatment and quality standards despite the national challenges of rising demand and the pressures for emergency care within our local health economy. "

2.1 An overview of performance

Statement from the chief executive

During 2016/17 Queen Victoria Hospital (QVH) has continued to strive for the delivery of targets for timely treatment and quality standards despite the national challenges of rising demand and the pressures for emergency care within our local health economy.

In some of our tertiary services, pressures in other NHS organisations have meant that we received referrals late into a patient's pathway, challenging us to maintain our strong performance on waiting times.

In course of the year QVH saw a change in the balance of activity with an increased proportion of surgery carried out as day cases rather than inpatient stays. Patients benefit from shorter hospital stays and being able to recover in the comfort of their own home, and we successfully developed plans during the year to adjust to the changing pattern of clinical practice at the hospital.

QVH has supported the local health economy through the continued development of community based services, such as ear, nose and throat (ENT) clinics, which aim to reduce demand on secondary care providers.

We are actively engaged within our local Sustainability and Transformation footprint, and are working with partner organisations to ensure efficient, high quality NHS services for both our local population and the wider area served by our more specialist work.

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

In April 2016 the Care Quality Commission (CQC) stated that patient care at QVH is outstanding. The inspectors found compassionate and considerate care throughout the hospital, with numerous examples of staff going above and beyond what would be expected. The CQC reported that staff have a clear culture of compassion and an exceptionally strong awareness and empathy with patients, with excellent emotional support for both patients and carers. In June 2016, the national NHS inpatient survey showed that QVH continues to achieve some of the best feedback from patients in the country. In July 2016 the national cancer patient survey showed that patients rate QVH as one of the very best hospitals in the country for cancer care.

In a tough year for the NHS as a whole, it is testament to the dedication of our staff that patient feedback remains excellent.

Statement of the purpose and activities of the foundation trust

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

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

In 2016/17, the principal activities of the trust were the provision of:

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

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

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

QVH also receives referrals from these hospitals and from April 2017 will be undertaking all the trauma and inpatient head and neck work from East Sussex Healthcare NHS Trust. This transfer excludes day case, outpatient follow up and oncology activity. QVH also provides community based clinical services into which GPs can refer. These are in a range of sites such as some of the community hospitals in Kent and Sussex. QVH has also, in the last year, expanded into providing locally based urology and ENT services.

A brief history of the foundation trust and its statutory background

QVH is a specialist NHS hospital providing life-changing reconstructive surgery, burns care and rehabilitation services for people across the South of England.

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

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

QVH was authorised as one of the country's first NHS foundation trusts in July 2004. We have around 7,480 public members in Kent, Surrey, Sussex and the boroughs of South London.

Keys issues and risks that could affect the foundation trust in delivering its objectives

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

1. Outstanding patient experience

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

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

2. World class clinical services

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

   As a stand-alone specialist surgical hospital, the absence of co-located general medical, paediatric and diagnostic services puts pressure on the ability of the Trust to provide a safe and effective out-of-hours service, and the mitigation of this through partnerships with neighbouring trusts requires continuous review.

3. Operational excellence

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

   The principle risks to delivery of this objective are the time needed for complex diagnostics in our more specialist work and the timeliness of referrals from partner trusts. These risks are mitigated by robust planning and regular contact with other trusts to improve processes.

4. Financial sustainability

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

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

5. Organisational excellence

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

   The principle risk to delivery of this objective is the ability of the Trust to recruit and retain staff, particularly in critical care and theatres, with use of temporary and agency staff impacting on job satisfaction. This will be a key area of work in 2017/18.

The Board Assurance Framework model (BAF) introduced during 2015/16 continues to evolve and was reviewed by the internal auditors as part of the 2016/17 annual audit committee plan. The BAF and corporate risk register are presented in full at every public board meeting. Both tools set out the measures in place to mitigate and manage risks and track progress and both were updated regularly in 2016/17. Papers for meetings of the board of directors held in public are published on the QVH website and are available in full from: www.qvh.nhs.uk/about-us/board-of-directors/meetings-in-public

Going concern

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

2.2 Performance analysis

How we measure performance

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

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

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

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

Analysis and explanation of development and performance

Governance

Following a comprehensive review of governance in 2015/16 which resulted in changes to the board subcommittee structure, 2016/17 was the first full year working with the new governance structures. During the year each board subcommittee carried out a review of effectiveness, with minor changes made to terms of reference and internal processes. The board also conducted an annual review of the standing orders and standing financial instructions, the reservation of powers and scheme of delegation.

During 2016/17 a change was proposed and agreed for the quality and governance committee to meet bimonthly from April 2017 instead of monthly. This committee is responsible for oversight of the Trust's performance in safety, effectiveness and patient experience as well as the governance structures and processes which support decision making and accountability in these areas.

The board is assured, as recorded in the annual effectiveness review considered in January 2017, that an effective governance structure is in place to enable and support QVH to meet its strategic objectives and ensure compliance with regulatory requirements; and the governance structures are fit for purpose and in line with best practice in the NHS and other sectors.

In 2017/18 QVH plans to commission an independent review of leadership and governance arrangements in line with guidance from NHS Improvement, seeking to identify areas of the leadership and governance of the Trust where further targeted development work may deliver improvements.

Care quality

The Care Quality Commission (CQC) presented its findings from the planned inspection in November 2015 at the quality summit in April 2016. Its judgement of the quality of care offered by QVH was based on a combination of the inspection findings, information from the CQC intelligent monitoring system, information submitted by QVH, and information given by the public and stakeholder organisations.

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

The Trust presented a detailed response to the recommendations at the quality summit and then a formal action plan to address the small number of recommendations. This plan is now also most fully complete and is monitored by the quality and governance committee on behalf of the board of directors.

To provide further assurance that the Trust meets the CQC fundamental standards, QVH has developed 'compliance in practice'. This is an internal inspection process which mirrors the five CQC domains. A wide range of staff, governors and stakeholders participate in this process to provide a range of perspectives and constructive challenge. Inspections within the clinical areas are undertaken on a monthly basis. The results of compliance in practice inspections are sent to the ward matrons and actions are monitored by the head of nursing. A quarterly report is presented to the quality and governance committee.

No concerns about the quality of care at QVH were raised in 2016/17 by NHS Improvement (NHSI) or the CQC. The Trust continues to provide the CQC with a monthly report on the fundamental standards of care, and quarterly performance reviews with NHSI commenced towards the end of 2016/17.

Infection control

QVH had two cases of Clostridium difficile in 2016/17 against a target of zero. The Trust has worked closely with commissioners and clinicians to fully understand the root cause of the infections and identify learning. QVH had no cases of MRSA bacteraemia during 2016/17.

Waiting times

QVH achieved the following against the 92% referral to treatment targets for 2016/17:

QUARTER	TRAJECTORY TARGET	ACHIEVEMENT
Q1	92%	92.1%
Q2	92%	91.1%
Q3	92%	91.8%

Results for quarter 4 are not included as these were not verified within the year 2016/17.

As can be seen, where the Trust misses the target, this is by a small margin. The specialist nature of QVH sub-specialties means that tiny shifts in either demand or capacity have a significant impact on referral to treatment performance. Other issues are late referrals, an increasing number of clock starts, and growth in referrals in specific areas. Plans have been developed in response to increased referrals and will come into place during the first quarter of 2017/18.

QVH continues to focus on reducing the number of patients with long waits, alongside ensuring that all patients are prioritised according to clinical urgency and in chronological order.

A trajectory target was agreed within the Sussex and East Surrey Sustainability and Transformation Plan area for cancer waiting times. This target is for the first definitive treatment occurring within 62 days of an urgent GP referral for suspected cancer. The quarterly figures were as follows:

QUARTER	TRAJECTORY TARGET	ACHIEVEMENT
Q1	81.5%	81.1%
Q2	81.6%	81.2%
Q3	85.3%	82.6%

Results for quarter 4 are not included as these were not verified within the year 2016/17.

The trajectory target was missed by a narrow margin, with the main issues being a very small denominator (where one patient can have a several percentage point impact) and late referrals from other trusts. To minimise this we continue to work closely with referring trusts, including regular liaison with off-site management teams to improve processes for joint pathways; discussions with individual trusts when an immediate breach has occurred; and closer liaison with health records managers so that the cancer administration team have full access to all oncology referrals. Due to the specialist nature of our work, patients referred to QVH often need complex diagnostics and preparation for surgery which can impact on achievement of the 62 day target.

The numbers of patients treated in sleep, skin and maxillofacial services has increased. Two week wait referrals for suspected skin cancer increased by 20% in 2015/16 with a 19% conversion rate to requiring cancer surgery. It is expected that the yearly increase for 2016/17 will be still greater.

Financial plan

QVH planned to deliver an operational surplus of £1.9m in 2016/17; including an expectation of a £0.9m allocation from the Sustainability and Transformation Fund. Significant cost pressures emerged during the year, principally related to a decrease in both critical care and minor injuries unit activity and a continuing shift in elective case-mix. The Trust formulated and delivered plans to address the financial gap and delivered the planned target and associated control total, £2.2m surplus after adjusting for the impact of donated depreciation, as set by NHS Improvement.

The key financial financial performance indicators for 2016/17 are detailed in the table below:

KEY FINANCIAL PERFORMANCE INDICATORS		
	Plan £000	Actial £000
Reported financial performance	1,927	2,985
Control total	2,215	3,211
Sustainability and Transformation Fund	900	1,673

- Reported finance performance of £3.0m surplus. The performance of the Trust is assessed by regulators before the impact of revaluation on the income and expenditure account. The Trust delivered a surplus for the year of £1.9m including the impact of a £1.1m of the revaluation associated impairment charge. In order for the regulator to assess the reported financial performance of the Trust, the £1.1m impairment adjustment is reversed, increasing the reported surplus to £3.0m.
- The Trust exceeded the internal plan and control total by £1.0m; this was principally due to the additional STF allocated to the Trust (£0.8m) as part of STF incentive and bonus schemes.
- The overall income and expenditure position, as detailed in the statement of comprehensive income set out in the accounts at section 6 is a surplus of £3.3m including the effect of revaluation adjustments to the income and expenditure account and the revaluation reserve.

Statement of comprehensive income

The table below is an extract of the table in the accounts at section 6 that shows the total value for income and expenditure for the financial year.

STATEMENT OF COMPREHENSIVE INCOME FOR THE PERIOD ENDED 31 MARCH 2017	
	2016/17 £000
Operating income	**68,532**
Operating expenses	**-65,291**
Operating surplus/(deficit)	**3,241**
Net finance costs	**-1,328**
SURPLUS/(DEFICIT) FOR THE YEAR	**1,913**
Other comprehensive income:	
Revaluation gains/(losses) on property, plant and equipment	2,162
Impairment through revaluation reserve	-766
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD	**3,309**

An independent professional valuer completed a full revaluation of all land, buildings and fixtures in year. There was a £0.3m increase in the assets' values arising from the revaluation exercise, £1.4m was recognised in the revaluation reserve and there was a £1.1m impairment charge to the income and expenditure account to reflect the reduction in value of specific assets.

Income

The Trust received £62.0m, the majority of its income, from the provision of healthcare services.

In addition, the Trust received income of £1.7m from Health Education England to support the cost of providing training and education to medical and other NHS staff and £1.7m of Sustainability and Transformation funding.

Operating expenses

The Trust incurred £65.3m of operating expenses in 2016/17. This includes costs of £43m (66% of total operating expenditure) to employ, on average over the year, 904 members of staff.

Operational non pay expenditure includes supplies and services costs of £11m, drug costs of £1.4m, premises costs of £3.6m and depreciation & amortisation of £2.8m. There was an impairment charge of £1.1m to reflect the reduction of the value of assets.

Capital

Capital expenditure equated to £3.1m in 2016/17; in line with the agreed plan. The table below details the investments made:

CAPITAL PROGRAMME 2016/17	
	£000
Building and infrastructure	**1,255**
Medical equipment	**760**
Information, management and technology	**1,041**
TOTAL	**3,056**

Cash

The Trust has a cash balance of £7.8m, prior to the receipt of funds relating to the delivery of the control total, which represents c.40 days of operating expenditure. The interest received by the Trust during 2016/17 was low, reflecting current economic conditions. The majority of funds are invested with the Government Banking Service (GBS).

Environmental and sustainability report

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

The key objectives with regard to sustainability are set out below and will be refreshed in 2017/18:

- Re-launch the sustainability group
- Critically review and update sustainability related strategies, policies and plans
- Develop phased action plans to address energy, water and carbon management
- Recycling water, use of grey water systems and sustainable drainage systems on the estate
- Waste reduction and recycling
- Energy efficiency management through controls in buildings and site design
- Sign up to the good corporate citizenship assessment model, and actively raise awareness at every level in the Trust
- Staff engagement and communication.

Our carbon footpring

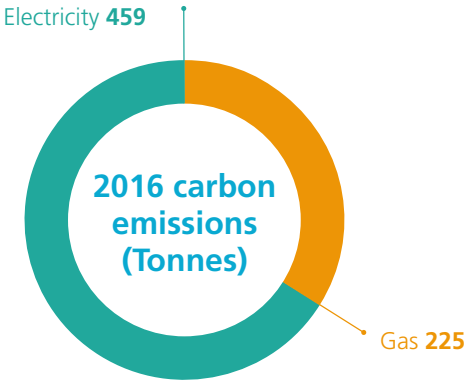
In 2010 our carbon footprint was 655 tonnes, as assessed by the Carbon Trust. Since then, the Trust has delivered a number of carbon reducing schemes including:

- Decentralising of steam boilers
- Commissioning new buildings with a rating of good on the BREEAM sustainability assessment
- Investment in energy efficient and low maintenance LED lighting during refurbishments and capital projects
- Installation of new double glazed windows in a number of buildings
- Improvement of roof insulation in a number of buildings during roof refurbishments
- Installation of cavity insulation on a number of capital projects
- Development of a new integrated travel plan.

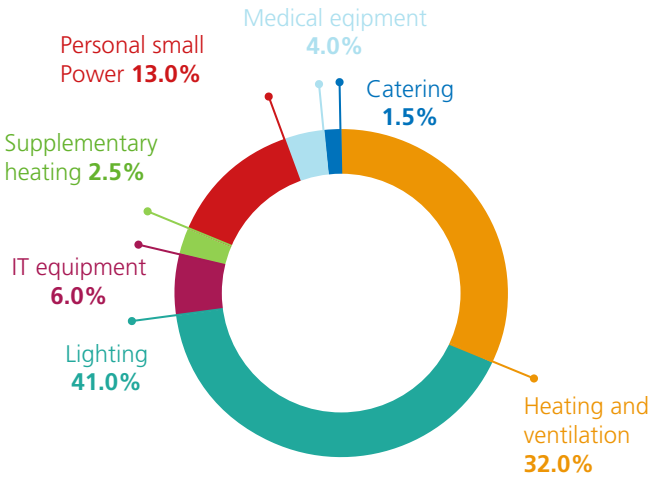
Using the latest modelling guidance provided by the Sustainable Development Unit, we calculate the Trust's carbon footprint as 684 tonnes of carbon; an increase of 4.2% since 2010. The increase is due to site and service expansion with a number of new buildings on site including a ten theatre complex, maxillofacial and outpatient buildings.

Specific carbon reducing schemes identified for implementation in 2017/18 are:

- Ensuring the correct setting of previously installed variable speed drives on air handling units
- Installation of variable speed drives fitted to larger fan motors where applicable
- Full review of building management system and further enhancement of the system to monitor plant equipment across the site
- Improvement to plant and pipework insulation
- Smart metering installation throughout the Trust to provide better data analysis of usage
- Continued programme of upgrades of aged and inefficient plant, including installation of energy efficient condensing boilers
- Review of waste management contract
- Implementation of active travel plan for our staff, our service users and our visitors
- Energy audits.



Our electricity usage breakdown



Energy

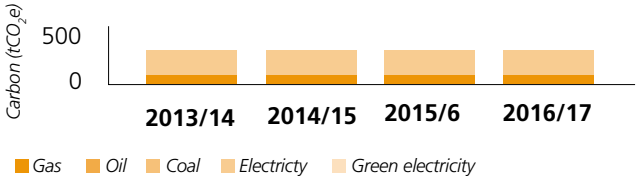
The Trust has been investing in energy efficient technologies and has a four year programme designed to replace all existing lighting with low energy and low maintenance LED lighting. This technology will deliver 75% savings in energy consumption compared with existing lighting units.

There is also a programme to replace all inefficient boilers with condensing boilers over the next four years. In 2017/18 we plan to replace at least ten boilers which have been identified as end-of-life under the backlog maintenance programme.

Further energy reducing schemes will include correct lagging of pipework throughout the Trust, reducing heat losses.

We spent £593,627 on energy last year, which is a 2% decrease on energy spend from the previous year, despite the increase in activity on site, the addition of new equipment and an increase of 3.8% in terms of 'occupied floor area'.

Carbon emissions - energy use



Waste reduction and recycling

Recycling facilities continue to be rolled out across QVH. The current waste contract is being reviewed to see where further improvements can be made. Our waste provider treats clinical waste by incineration, with 100% steam recovery converting the heat back to energy and supplying six hospitals near the treatment plant. In 2016/17 98 tonnes of our waste was treated this way with 100% residual waste (flock) recovery on a further 29.59 tonnes.

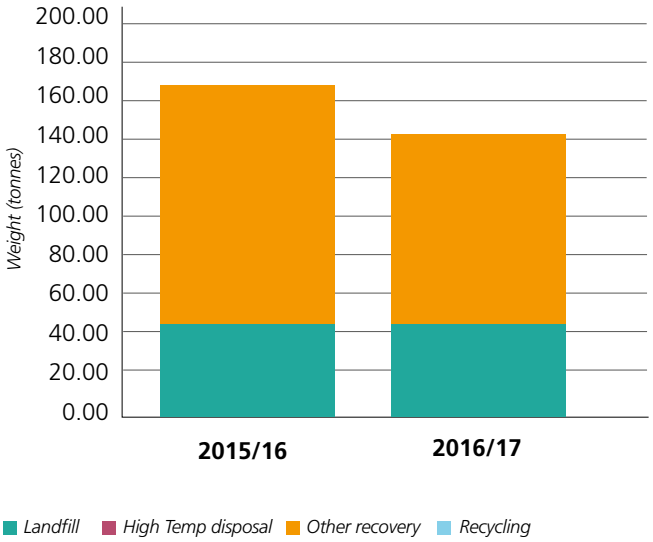
Areas for improvement are:

- Improving waste segregation throughout the Trust
- Investigating further options for non-infectious waste disposal
- Introducing feminine hygiene units
- Reducing the volume of waste bagged as clinical and so requiring heat treatment
- Introducing an 'offensive' waste stream using tiger bags.

Waste recycling

Waste		2015/16	2016/17
Recycling	(tonnes)	0.00	0.00
	tCO_2e	0.00	0.00
Other recovery	(tonnes)	129.00	106.00
	tCO_2e	2.58	2.23
High temp disposal	(tonnes)	0.00	0.00
	tCO_2e	0.00	0.00
Landfill	(tonnes)	44.00	44.00
	tCO_2e	10.75	13.64
Total waste (tonnes)		173.00	150.00
% Recycled or re-used		0%	0%
Total waste tCO_2e		13.33	15.87

Waste breakdown



Travel plan

The Trust has been working in partnership with a transport consultant on the development and delivery of an active travel plan designed to:

- promote and encourage the use of more sustainable travel modes
- reduce congestion and ease the demand for parking spaces
- encourage staff to consider alternatives to single occupancy car journeys and help provide space for staff with no other option than to drive to work
- reduce carbon emissions, air and noise pollution
- provide documentation to support any future planning applications.

The travel plan provides a framework for the longer term management of travel to and from the hospital campus. Reviews were undertaken to assess issues, and sustainable travel opportunities for the site were identified through on-site observations and consultation with staff, volunteers, on-site partners, patients and visitors.

A number of options have been proposed and are being reviewed by the Trust.

The plan has been reviewed and approved by sustainable transport officers from West Sussex County Council who have responsibility for ensuring that such documents meet local travel plan requirements.

Social, community and human rights issues

QVH maintains close connections with the local community in East Grinstead and the surrounding areas, including regularly sharing information through the local press and engaging through social media as well as email updates for our 7,480 Foundation Trust members. In addition the QVH governors attended a number of community meetings in 2016/17 to talk to local groups about the work of the hospital.

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

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

In 2016/17 we began work on our travel plan, engaging with the local community as well as visitors and patients over how best to promote healthy and green options for staff and patients travelling to the hospital, and how to alleviate the issue of congested parking on the hospital site. This work will continue in the next year.

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

Overseas operations

QVH has no overseas operations.

Steve Jenkin

Chief Executive and Accounting Officer

25 May 2017

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Accountability report

"The QVH strategy for quality is integral to the Trust's strategy of delivering excellence whilst sustaining financial stability."

3.1 An overview of performance

Disclosures

Directors' disclosures

In 2016/17 the following individuals served as directors of Queen Victoria Hospital NHS Foundation Trust:

NAME	POSITION
Ginny Colwell	Non-Executive Director
Steve Fenlon	Medical Director (to 30 September 2016)
Beryl Hobson	Chair
Steve Jenkin	Chief Executive (from 14 November 2016)
Ian Playford	Non-Executive Director (to 28 October 2016)
Ed Pickles	Medical Director (from 1 October 2016)
Lester Porter	Senior Independent Director
Clare Stafford	Director of Finance
Jo Thomas	Director of Nursing
John Thornton	Non-Executive Director
Richard Tyler	Chief Executive (to 13 November 2016)

Ginny Colwell was appointed non-executive director for a three-year term on 21 April 2016. The background to this appointment is included in the board of directors register in section 7.1.

Biographies for all current directors of the trust are provided in section 7.3. Details of company directorships and other significant interests held by directors or governors which may conflict with their management responsibilities can be accessed from the papers of meetings of the board of directors held in public. These are available in full from the Queen Victoria Hospital (QVH) website at www.qvh.nhs.uk/about-us/board- of-directors/meetings-in-public.

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

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

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

Other disclosures

In 2016/17 the Trust neither made nor received any political donations.

The better payment practice code requires QVH to pay all valid invoices within the contracted payment terms or within 30 days of receipt of goods or a valid invoice, whichever is later. The performance achieved in 2016/17 compared to 2015/16 is shown in section 6, annual accounts.

In 2016/17 the Trust did not incur any expenditure relating to the late payment of commercial debt under the Late Payment of Commercial Debts (Interest) Act 1998.

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. In 2016/17 QVH met this requirement.

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

Enhanced quality governance reporting

Oversight of governance systems is the responsibility of the board. Good governance is an essential part of the Trust's ability to continue to provide safe, high quality and sustainable care for all our patients. Part of the assurance process for this is the three-yearly risk assessment framework review which the Trust will undertake by commissioning independent assessors during 2017/18.

All the terms of reference for the committees of the board have been reviewed during 2016/17. The new Board Assurance Framework model (BAF) introduced during 2015/16 continues to evolve and was reviewed by the internal auditors as part of the 2016/17 annual audit committee plan. The BAF and corporate risk register are presented in full at every public board meeting.

BETTER PAYMENT PRACTICE CODE PERFORMANCE				
	Year ended 31 March 2017		Year ended 31 March 2016	
	Number	£000	Number	£000
Total bills paid in year	19334	27,067	18,262	27,096
Total bills paid within target	15436	20,505	15,401	22,359
Percentage of bills paid within the target	**80%**	**76%**	**84%**	**83%**

At every public board meeting there are detailed reports on quality, performance, finance and workforce. There is opportunity for robust challenge and debate about these reports. The directors work collaboratively in order to meet the Trust's key strategic objectives and provide leadership and oversight of the systems in place for care provision and service delivery; again this is scrutinised at public board meetings. In addition to this governance process, the non-executive chair of each board committee presents a report to the board about the level of assurance and key items for approval or discussion.

The QVH strategy for quality was developed during the latter part of 2016/17 and sets out a three year quality strategy which is integral to the Trust's strategy of delivering excellence whilst sustaining financial stability. The strategy sets out how the Trust will sustain or improve the quality and safety of our services, and measures to demonstrate achievement of milestones. The director of nursing is the executive lead for quality within the Trust and will lead on the implementation of this strategy.

QVH has a robust quality governance framework which provides the board of directors, council of governors, senior managers, clinicians, commissioners and regulators with assurance that care never falls below the fundamental standards which every patient and indeed everybody has a right to expect. This framework also provides assurance that the process for quality governance reporting is embedded throughout the whole organisation.

The framework consists of agreed pathways for feedback and escalation from all quality groups within the organisation to the quality and governance committee. The quality and governance committee has an annual work plan and the terms of reference which enable responsive action including commissioning additional quality 'deep dives' to investigate issues of concern or where additional assurance is required.

Quality is a consideration at all key Trust meetings including the executive management team, clinical governance group, governance and business unit meetings, clinical cabinet and the joint hospital governance group. Together these sessions contribute to a quality-focused culture which empowers managers and clinicians to lead on local quality matters. The quality and governance committee receives regular updates from these forums to enable the committee to make decisions about the level of governance and quality assurance within the organisation and make recommendations to the board.

Each team or department has its own monthly governance/business meeting chaired by the clinical lead and supported by the risk management team and data from the informatics team. There is monthly scrutiny of the departmental risk register with any risk scoring 12 or above escalated to the corporate risk register. This system ensures the focus on the patient as well as the service provision in terms of safety, effectiveness and experience.

The monthly performance review for all business units has become more established during 2016. Any deviation from expected performance for quality, performance, finance or human resources is reported and a recovery plan or mitigating actions are agreed. Further details can be found in section 6, annual accounts. The lead commissioner also undertakes a bi monthly performance review with the Trust, reviewing performance against local and national contracts and targets as well as commissioning for quality and innovation (CQUIN) and patient experience.

All serious incidents are reported to the board. The full root-cause analysis report and action plan are submitted for discussion to the quality and governance committee. The completion of the actions and learning from the incident are also monitored at this committee.

In 2016/17 there were no material inconsistencies between:

- the annual governance statement
- annual and quarterly board statements required by the Single Oversight Framework
- the corporate governance statement submitted with the annual plan
- the quality report and the annual report
- reports arising from the CQC.

NHS Improvement national priority indicators

NHS Improvement uses the following national access and outcomes measures to make an assessment of governance at NHS foundation trusts. Performance against these indicators is used as a trigger to detect any governance issues. **Results for quarter 4 are not included as these were not verified within the year 2016/17.**

			Performance			Quarterly trend		
		National priority indicator	Target	Annual	RAG	Q1	Q2	Q3
Safety	**Infection control**	Clostridium difficile acquisitions	0	2		1	0	1
Experience	**Referral to treatment times**	% incomplete pathways less than 18 weeks referral to treatment times	92%	91.6%		92.1%	91.1%	91.8%
	Minor injuries unit access	Attendees completing treatments and leaving within 4 hours in minor injuries unit	95%	99.1%		99.1%	99.2%	99.6%
Effectiveness	**Cancer access – initial appointments**	Urgent cancer referral seen within 2 weeks	93%	94.2%		90.7%	96.4%	95.9%
	Cancer access – initial treatments	% of cancer patients treated within 62 days of urgent GP referral	85%	81.7%		81.1%	81.2%	82.6%
		% patients treated within 62 days form screening referral Screening service not offered at QVH, all patients are on a shared pathway with other providers	90%	54.5%		50%	100%	50%
		% treatment started within 31 days from decision to treat first treatment	96%	93.3%		91.2%	95.1%	93.4%
		% treatment started within 31 days from decision to treat subsequent treatment	94%	94.6%		98.0%	90.1%	95.5%

Results for quarter 4 are not included as these were not verified within the year 2016/17.

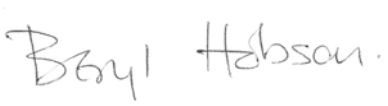
A detailed account of quality can be found in the quality report at section 4 and in the annual governance statement at section 3.7. This includes:

- registration with the Care Quality Commission (CQC) - arrangements for monitoring improvements in the quality of healthcare and progress towards meeting any national and local targets, incorporating CQC assessments and reviews and the NHS foundation trust's response to any recommendations made
- Commissioning for Quality and Innovation payment framework - progress towards targets as agreed with local commissioners, together with details of other key quality improvements
- patient experience achievements; details of new or significantly revised services
- reporting of national core quality indicators, including information on complaints handling.

3.2 Remuneration report

Annual statement on remuneration

In 2016/17 the nomination and remuneration committee implemented the pay strategy that had been approved by the committee in 2015/16 in recognition that senior level pay at the Trust had become out of step with NHS benchmarks. After extensive benchmarking the salary of the chief executive was increased in 2016, based on the median range of chief executive salaries. The director of human resources and organisational development received an award in line with the lower median for equivalent posts. Both the chief executive and the director of human resources and organisational development left the Trust later in 2016. The salaries of the director of finance, director of nursing and director of operations increased by 1% in line with the nationally determined Agenda for Change pay increase.



Beryl Hobson
Trust Chair and Chair of the nomination and remuneration committee
25 May 2017

Senior managers' remuneration policy

The salary and pension entitlements of senior managers are set out in the section below showing information subject to audit.

The QVH approach to remuneration continues to be influenced by national policy and local market factors. The majority of staff receive pay awards determined by the Department of Health in accordance with their national terms and conditions, such as Agenda for Change, and the pay review bodies for doctors and dentists. The first doctors on the new junior doctors' contract started in February 2017.

QVH does not intend to implement separate arrangements for performance related pay or bonuses in the coming financial year, although this will be kept under regular review.

Senior managers' pay arrangements are subject to approval by the nomination and remuneration sub-committee of the board of directors. In early 2016/17, the committee received pay recommendations from the director of human resources and organisational development based on evidence from the pay and reward consultants, e-reward.co.uk, on pay for senior managers in NHS trust and foundation trusts. This resulted in the committee agreeing to increase the salaries of the chief executive and director of human resources and organisational development in line with national benchmarking. Both post holders subsequently left the Trust in 2016.

The effectiveness and performance of senior managers is determined through performance appraisal, linked to the current QVH 2020 long-term strategy. This provides five key strategic objectives from which a set of individual objectives are developed. These are reviewed throughout the year by the chief executive to determine progress and achievement. They also underpin the Board Assurance Framework, reviewed at every board meeting and by sub-committees of the board.

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

periods for Agenda for Change staff is followed and is determined by salary banding. The maximum in such cases is three months' salary and is in line with current employment legislation.

Senior managers paid more than £142,500[1]

The trust employed two senior managers on salaries more than £142,500 in 2016/17. Both appointments were made before the Treasury guidance and reporting arrangements came into effect. One of the posts was the previous chief executive who left in November 2016; the salary has been benchmarked against national and local pay comparisons. The salary of the new chief executive is below this level. The medical director receives an allowance for board responsibilities beyond clinical duties that takes his remuneration above £142,500.

Non-executive directors table

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

Service contract obligations

None to disclose.

Policy on payment for loss of office

Termination payments are made within the contractual rights of the employee and are therefore subject to income tax and national insurance contributions. This also applies to senior managers whose remuneration is set by the nomination and remuneration committee. Where a senior manager receives payment for loss of office, this is determined by their notice period and does not usually exceed six months.

Statement of consideration of employment conditions elsewhere in the foundation trust

QVH, through the nomination and remuneration committee, takes into account the annual pay awards for all staff in determining pay increases for senior managers and directors. Pay at senior levels was increased in 2016/17 for the first time since 2012 during which time increases for staff on Agenda for Change terms and conditions, and other staff subject to national bargaining, have averaged 1% each year. In 2016/17, the nomination and remuneration committee approved an increase of 1% to the pay of three members of the executive team and further to extensive bench marking and in line with the pay strategy increased the salary of the chief executive and director of human resources and organisational development.

In addition to the pay and conditions of other NHS staff, the nomination and remuneration committee also took into account comparison data taken from the Income Data Services (IDS) NHS boardroom pay report 2015. This highlights the pay for a number of senior level posts and includes total remuneration. The comparisons considered were basic salary for the post in similar NHS hospitals and variations by geographic location. The Trust does not pay bonus payments to any senior managers and therefore the comparison with basic pay at other trusts is appropriate in determining pay increases.

Annual report on remuneration

Information not subject to audit

Service contracts

NAME	POSITION	START DATE	TERM	NOTICE PERIOD
Stephen Fenlon	Medical Director	1 April 2013 (Left 2 October 2016)	Permanent	3 months
Steve Jenkin	Chief Executive	14 November 2016	Permanent	6 months
Ed Pickles	Medical Director	1 October 2016	Permanent	3 months
Clare Stafford	Director of Finance	1 June 2015	Permanent	3 months
Jo Thomas	Director of Nursing	1 June 2015	Permanent	3 months
Richard Tyler	Chief Executive	1 June 2013 (left 12 November 2016)	Permanent	6 months

[1] £142,500 is the threshold used in the Civil Service for approval by the Chief Secretary to the Treasury, as set out in guidance issued by the Cabinet Office. The Cabinet Office approvals process does not apply to NHS foundation trusts but this is considered a suitable benchmark above which NHS foundation trusts should make this disclosure.

Remuneration committee

The nomination and remuneration committee met three times in 2016/17 to review and make recommendations to the board of directors on the composition, balance, skill mix, remuneration and succession planning of the board. Additionally, the committee makes recommendations on the appointment of executive directors. The September 2016 meeting had the primary aim of agreeing the appointment of the medical director and the nomination and the remuneration package of the new chief executive.

The board of directors has delegated authority to the committee to be responsible for the remuneration packages and contractual terms of the chief executive, executive directors and other senior managers reporting to the chief executive.

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

The committee was materially assisted in its considerations at all meetings held in 2016/17 by Graeme Armitage, director of human resources and organisational development until May 2016 and then Geraldine Opreshko, director of human resources and organisational development from June 2016.

Disclosures required by the Health and Social Care Act

Directors

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

Governors

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

1 APRIL 2016 – 31 MARCH 2017		
Total number of governors in office	**Number of governors receiving expenses in 2016/17**	**Aggregate sum of expenses paid in 2016/17 (rounded to the nearest £00)**
27 served for all or part of 2016/17	1	£33.40

Information subject to audit

SALARY AND PENSION ENTITLEMENTS OF SENIOR MANAGERS							
A) Remuneration	**2016/17**						
Name and title	**Salary**	**Benefits in kind**	**Annual performance-related bonus**	**Long-term performance-related bonus**	**Pension-related benefits**	**Other remuneration**	**Total remuneration**
	(bands of £5,000) £000	Rounded to the nearest £100	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000
V Colwell (Non-Executive Director)	10-15	300	0	0	0	0	15-20
S Fenlon[1] (Medical Director)	75-80*	0	0	0	0	0	0-5
B Hobson (Chair)	40-45	600	0	0	0	0	45-50
S Jenkin[2] (Chief Executive)	50-55	0	0	0	10-12.5	0	65-70
E Pickles[3] (Medical Director)	70-75**	0	0	0	95-97.5	0	165-170
I Playford[4] (Non-Executive Director)	0	0	0	0	0	0	5-10
L Porter (Non-Executive Director)	10-15	0	0	0	0	0	10-15
C Stafford (Director of Finance)	125-130	100	0	0	37.5-40	0	165-170
J Thomas (Director of Nursing)	105-110	0	0	0	42.5-45	0	150-155
J Thornton (Non-Executive Director)	10-15	0	0	0	0	0	10-15
R Tyler[5] (Chief Executive)	95-100	0	0	0	40-42.5	0	135-140

* Salary attributable to the medical director's clinical role is £71,078.07

** Salary attributable to the medical director's clinical role is £63,233.52

[1] with effect until 30 September 2016

[2] with effect from 14 November 2016

[3] with effect from 1 October 2016

[4] with effect until 28 October 2016

[5] with effect until 13 November 2016

SALARY AND PENSION ENTITLEMENTS OF SENIOR MANAGERS

A) Remuneration	2015/16						
Name and title	**Salary**	**Benefits in kind**	**Annual performance-related bonus**	**Long-term performance-related bonus**	**Pension-related benefits**	**Other remuneration**	**Total remuneration**
	(bands of £5,000) £000	Rounded to the nearest £100	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000
V Colwell (Non-Executive Director)	10-15	1,300	0	0	0	0	15-20
S Fenlon (Medical Director)	150-155*	0	0	0	30-32.5	0	185-190
B Hobson (Chair)	40-45	2,000	0	0	0	0	45-50
I Playford (Non-Executive Director)	10-15	200	0	0	0	0	10-15
L Porter (Non-Executive Director)	10-15	0	0	0	0	0	10-15
C Stafford (Director of Finance)	100-105	0	0	0	25-27.5	5-10	135-140
J Thomas (Director of Nursing)	100-105	0	0	0	227.5-230	0	330-335
J Thornton (Non-Executive Director)	10-15	0	0	0	0	0	10-15
D Tkaczyk (Interim Director of Finance)	55-60	0	0	0	0	0	55-60
R Tyler (Chief Executive)	145-150	0	0	0	15-17.5	0	160-165

* Salary attributable to the medical director's clinical role is £137,403.12

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 2017**	**Lump sum at age 60 related to accrued pension at 31 March 2017**	**Cash equivalent transfer value at 1 April 2016**	**Real increase in cash equivalent transfer value**	**Cash equivalent transfer value at 31 March 2017**	**Employers contribution to stakeholder pension**
	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	£000	£000	£000	£000
S Fenlon (Medical Director) left 30 September 2016	0	0	45-50	130-135	873	0	856	0
S Jenkin (Chief executive) from 14 November 2016	0-2.5	0-2.5	0-5	0	0	5	15	0
E Pickles (Medical Director) from 1 October 2016	2.5-5	2.5-5	30-35	85-90	419	39	497	0
C Stafford (Director of Finance)	2.5-5	0-2.5	30-35	80-85	427	42	469	0
J Thomas (Director of Nursing)	2.5-5	0-2.5	30-35	90-95	548	52	600	0
R Tyler (Chief Executive) left 13 November 2016	0-2.5	2.5-5	35-40	115-120	690	41	757	0

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

No performance related bonus was paid in 2016/17 or 2015/16.

Other remuneration represents non-taxable relocation payments.

Ian Playford left the trust on 28 October 2016.

Richard Tyler left the Trust on 13 November 2016.

Steve Fenlon left the Trust on 2 October 2016.

Ginny Colwell was appointed non-executive director for a three-year term on 21 April 2016. The background to this appointment is included in the board of directors register in section 7.1.

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

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies.

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

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

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report.

Due to the lead time reaquired to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

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

The banded remuneration of the highest paid director/ member in the financial year 2016/17 was £137,500 (2015/16 £152,500). This was 4.8 times (2015/16 5.5) the median remuneration of the workforce, which was £28,457 (2015/16 £27,511). In 2016/17, 12 (2015/16, 9) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £142,742 to £205,702 (2015/16 £153,111-£194,543). The change in ratio is a result of the change in chief executive and medical director in year, the new appointments have comparatively lower annual remuneration packages.

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

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

Steve Jenkin
Chief Executive and Accounting Officer
25 May 2017

3.3 Staff report

Average staff numbers

The table below shows the average number of staff employed by the Trust each month in 2016/17.

	Chief executive	Executive directors	Non-executive directors	Other senior managers	All other employees	Total
Female	0	2	2	3	738	745
Male	1	1	2	0	228	231
Total						**976**

Data from 31 March 2017

Sickness absence data

In line with national guidance, the table shows the sickness absence for the calendar year January-December 2016.

Average full time equivalent staff 2016	Adjusted full time equivalent days lost (Cabinet Office definitions)	Average number of days of sickness absence per full time equivalent employee
850	5,606	6.6

Source: NHS Digital Sickness Absence Publication, based on data from the ESR Data Warehouse

PERMANENTLY EMPLOYED													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average
Headcount	996	987	982	981	988	992	983	980	977	969	965	964	**980**
FTE	847.54	841.40	839.51	836.03	839.99	845.26	839.51	837.43	833.80	826.75	820.27	820.03	**835.63**
TEMPORARY STAFF-BANK, LOCUM, AGENCY													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average
Non-medical bank	29.83	28.50	32.87	26.12	28.80	28.09	31.25	37.40	31.22	35.72	37.76	37.76	**32.11**
Non-medical agency	12.81	15.40	25.50	24.24	24.92	29.13	29.68	29.48	23.10	22.40	23.96	24.63	**23.77**
Medical locums	0.93	0.33	0.21	0.33	0.37	1.32	0.79	0.71	0.57	1.23	0.50	0.27	**0.63**
Medical bank	1.99	2.47	0.83	0.96	1.53	1.76	0.63	1.94	0.77	1.33	2.31	1.34	**1.49**
Medical agency	1.10	0.28	0.35	0.74	0.81	0.60	1.01	1.36	2.12	3.64	1.52	1.73	**1.27**
Total average full time equivalent staff numbers 2016/17													**894.90**

Staff policies and actions applied during the financial year

During 2016/17, QVH continued the work to ensure all staff policies are systematically reviewed and updated and comply with changes in legislation, and that employment policies are in line with current good practice and ensure that applicants and employees are treated fairly and equitably. Key staff policies reviewed in 2016/17 include:

- change management policy
- disciplinary policy
- capability policy.

Other action taken in year included the provision of:

- an improved appraisal scheme and toolkit
- a new pay protocol
- guidance on the use of social media.

Policies applied during the financial year for giving full and fair consideration to applications for employment made by disabled persons, having regards to their particular aptitudes and abilities.	QVH has a positive approach to applications from people with disabilities and makes adjustments where appropriate for interview and employment. The Trust signed up as a registered 'Disability Confident Employer' in 2016/17, and analysis shows that a higher proportion of disabled applicants are being shortlisted in relation to their comparator group, as those who meet the minimum essential criteria are guaranteed an interview as a part of this accreditation.
Policies applied during the financial year for continuing the employment of, and arranging appropriate training for, employees who have become disabled persons during the period.	The Trust continues to provide training sessions and ongoing support for managers and staff around disability, including a successful programme launched in 2016/17 around mental wellbeing. A new provider of occupational health services commenced February 2017. The occupational health service provider is very supportive of our disabled staff and is working with managers to ensure reasonable adjustments are made.
Policies applied during the financial year for training, career development and promotion of disabled employees.	Delivery of training is under regular review as part of the Trust's equality strategy action plan and implementation of the Equality Delivery System 2. QVH works with disabled staff as individuals, discussing their needs on a case-by-case basis. QVH is registered with the Disability Confident scheme and is committed to achieve the NHS Employers recommended Workforce Disability Equality Standard within the next year.
Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees.	For most of the year 2016/17, the executive team hosted monthly all staff briefing sessions. Chaired by the chief executive, the sessions included briefings on the Trust's latest quality, operational, financial and workforce performance metrics and analysis. Challenges in relation to targeting messages to the broad range of staff that would attend and the arrival of a new chief executive has led to a review and refresh of our communications and engagement activities with plans to launch a leadership 'Team Brief' encouraging face to face team feedback from managers cascading through the organisation. The new chief executive has also launched a monthly blog which directly encourages feedback and comment back from staff. The previous fortnightly electronic newsletter, Connect, became a weekly from autumn 2016 consolidating email traffic into one readable document and providing a reference point for key information of concern to employees. Important news and developments are reported to staff in real time by email whenever necessary. The intranet site for staff, Qnet, is being further enhanced to improve navigation and content.

Actions taken in the financial year to consult with employees and their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests.	QVH has good working relationships with its staff-side representatives and directors meet with them regularly to discuss the performance of the Trust in terms of its financial position and continuous improvement of care quality. Formal consultation with staff is driven through the joint consultation and negotiating committee comprising trade union and management representatives; and the local negotiating committee involving managers and medical staff representatives and including a British Medical Association representative.
Actions taken in the financial year to encourage the involvement of employees in the NHS foundation trust's performance.	In 2016/17 QVH continued with a number of initiatives introduced the previous year including breakfast sessions with the chief executive and chair, and staff and leadership briefings. These initiatives are in the process of being refreshed with a team brief approach soon to be implemented and a range of other initiatives being re-launched including staff excellence awards and recognition for long service. Whilst QVH has an open and supportive culture, it is important that we also provide other opportunities for staff to raise concerns safely without fear. At the end of 2016/17 the process was launched for staff to elect a Freedom to Speak up Principal Guardian and policies will be further updated to reflect this new role.
Information on health and safety performance and occupational health.	QVH has a health and safety committee which regularly receives reports from across the Trust highlighting any risks and how they are being addressed. In addition, the human resources department provides quarterly information on the support provided to staff through our occupational health and employee assistance providers. Data on this is also included the workforce reports to board. The contract with our occupational health provider came to a natural end and after a challenging tendering process we then approached other NHS providers in our geographical area for expressions of interest. From February 2016 the service is provided by a neighbouring Trust, Surrey and Sussex Healthcare NHS trust. We expect to see a number of enhancements to the services including an improved triage service, improved reporting and record keeping, enhancements to key policies, improvements in health surveillance and access to support seven days a week. We contract directly now for a more cost effective employee assistance provider. This provides all staff with a range of support, personal and professional including: • confidential counselling and legal advice for both work related and non-work issues • stress management • advice to staff on injuries at work • a 24-hour employee assistance programme which provides comprehensive, round the clock phone advice for all staff • access to online wellbeing portal.
Information on policies and procedures with respect to countering fraud and corruption	QVH takes fraud and corruption very seriously and takes steps to regularly review processes to ensure that opportunities for fraud to take place are minimised. This includes training sessions for staff and managers from the counter fraud team. We also act upon information provided by staff and encourage them to be open at all times where they feel their colleagues are not acting in the best interests of patients or the Trust. NHS Protect training has been revised and an annual counter fraud survey undertaken with staff.

Employee policy and service developments in the Trust require an equality impact assessment (EqIA) to encourage reflection on potential impacts to those with protected characteristics and human rights principles. As part of continued advancements the EqIA process is now embedded within the business case development process, and updated guidance has been provided to managers on carrying out these assessments.

The board of directors is provided with an annual report on progress against the equality strategy and the Trust publishes data relating to its equality profile on the website. To ensure the strategic approach remains relevant to the needs of our population and Trust staff the Equality Delivery System 2 and objectives are being refreshed with more recent data. Detailed work behind the Workforce Race Equality Standard and preparation for the Workforce Disability Equality Standard is underway, with heightened oversight over the equality agenda coming from a new workforce education and wellbeing group launched towards the end of 2016/17.

Staff survey results

a) Commentary

Our staff engagement score dropped slightly in the 2016 staff survey from 4.01 in 2015 to 3.87 in 2016. The average for specialist trusts in the QVH comparator group is 3.98, down from 4.01 in 2015. The overall engagement score for acute trusts in 2016 was 3.81.

Undoubtedly changes in the external NHS environment had an impact on QVH in the last 12 months and will continue to do so compounded about a lack of clarity and understanding in the general workforce about the impact of Sustainability and Transformation Plans as well as the impact of national staff shortages on the workforce, including theatre staffing and critical care.

Almost 56% of the total workforce responded to the survey, an increase of 6% on the preceding year.

Survey results have also shown staff continuing to recommend QVH as a place to receive treatment, putting QVH in the top ten of trusts in England, but a decline in general job satisfaction and communication between staff and managers in the workplace.

b) Summary of performance - results from the NHS staff survey

There were a number of indicators in 2016 which showed no difference in the majority of questions and there was a significant improvement in staff reporting their experience of harassment, bullying or abuse.

The Trust remains amongst the best in the country for staff recommending it as a place to receive care and treatments at 91%.

The main areas of focus are communication between senior managers and staff; feeling recognised and valued; team effectiveness; management interest in wellbeing and receiving feedback and this generally links to a decline in job satisfaction.

The Trust had already put in place a number of significant initiatives. These were not timely enough to impact on the staff survey results, but will go some way to addressing the concerns staff are expressing.

Further the Trust is using the Staff Friends and Family Test as a means to triangulate some of the outcomes of the survey, most notably around communications and feeling able to speak up.

Response rate				
	2015		2016	Trust improvement/ deterioration
	Trust	Trust	Benchmarking group (specialist) average	
Response rate	50%	56%	49%	Increase

Top 5 ranking scores				
	2015		2016	Trust improvement/
	Trust	Trust	Benchmarking group (specialist) average	
KF29	97%	94%	92%	decrease
KF 24	56%	73%	67%	Increase
KF17	28%	32%	33%	Increase
KF26	22%	25%	25%	Increase
KF27	24%	47%	47%	Increase/decrease
Bottom 5 ranking scores				
	2015/16		2015/16	Trust improvement/ deterioration
	Trust	Trust	Benchmarking group (specialist) average	
KF15	51%	49%	53%	decrease
KF13	4.01	3.94	4.07	decrease
KF23	1%	2%	2%	decrease
KF4	4.00	3.84	3.98	decrease
KF8	3.97	3.85	3.97	decrease

Expenditure on consultancy

During 2016/17, professional advice was taken from Cloud 21 on the development of a new information management and technology strategy for QVH. The advice and subsequent report was used to inform discussions and agree the next steps required to deliver local, sustainability and transformation footprint and national ambitions. The cost of consultancy services was £17,000.

In addition, the Trust contributed £15,000 to the cost of consultancy services linked to the development the Sussex and East Surrey Sustainability and Transformation Plan. Sustainability and transformation partnerships are a way for the NHS and local government to work together to improve and join up services to meet the changing needs of all the people who live in our area. There are 23 organisations in our partnership including clinical commissioning groups, providers and local authorities.

Off payroll engagements

Use of off-payroll arrangements is subject to authorisation by the board of directors' nomination and remuneration sub-committee. Off-payroll appointments of senior staff are kept to a minimum and are usually reserved for interim engagements when senior vacancies arise and cannot otherwise be managed. Such arrangements are usually subject to maximum periods of six months and, as such, are made in accordance with the regulations set by HMRC.

The rules of engagement have been changed centrally from April 2017.

All off-payroll engagements as of 31 March 2017, for more than £220 per day and that last for longer than six months	
	Number
Number of existing engagements as of 31 March 2017	1
Of which:	
Number that have existed for less than one year at the time of reporting	1
Number that have existed for between one and two years at the time of reporting	0
Number that have existed for between two and three years at the time of reporting	0
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	0
Confirmation:	
Please confirm that all existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.	Yes

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017, for more than £220 per day and that last for longer than six months	
	Number
Number of new engagements, or those that reached six months in duration between 1 April 2016 and 31 March 2017	2
Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and national insurance obligations	2
Number for whom assurance has been requested	0
Of which:	
Number for whom assurance has been received	
Number for whom assurance has not been received	
Number that have been terminated as a result of assurance not being received	

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017	
	Number
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	1
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements	12
Details of the exceptional circumstance that led to each of these engagements	Following the departure of the director of human resources and organisational development in May 2016, an interim appointment was made while a recruitment process was undertaken. However the chief executive resigned shortly afterwards and it was decided to delay recruitment to focus on a new chief executive appointment.
Details of the length of time each of these exceptional engagements lasted.	During 2016/17, the interim appointment noted above lasted from May 2016 to November 2016 and was made a fixed term contract from 1 December 2016.

Exit packages

Foundation trusts are required to disclose summary information on the use of exit packages agreed in the financial year. Staff exit packages are payable when the Trust terminates the employment of an employee before the normal retirement date or whenever an employee accepts voluntary redundancy in return for these benefits.

In 2016/17 QVH did not make any compulsory redundancies and did not agree any other staff exit packages outside contractual terms and conditions. There was no resource cost for staff exit packages in 2016/17.

2016/17			
	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
Total number of exit packages by type	0	5	5
Total resource cost	0	£89,600	-

2016/17			
	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000		3	3
£10,000 - £25,000		1	1
£25,001 - £50,000			
£50,001 - £100,000		1	1
£100,001 - £150,000			
£150,001 - £200,000			
>£200,000			
Total number of exit packages by type	0	5	5
Total resource cost	**0**	**£89,600**	-

Non-compulsory departure payments

The Trust made no non-compulsory departure payments in 2016/17.

In 2016/17, a number of restructures were carried out in corporate areas and as a result one individual chose to leave the organisation. In accordance with their contractual entitlements, an agreement was reached for them to leave the Trust with their notice paid in lieu.

2016/17		
Contractual Costs	Agreement Number	Total Value of Agreements £000
Voluntary redundancies including early retirement	1	£61
Mutual agreed resignations (MARS)	0	
Early retirements in the efficiency of the service	0	
Contractual payments in lieu of notice	4	£29
Exit payments following employment tribunals or court orders	0	
Non-contractual payments requiring HMT approval	0	
Total number of exit packages by type	5	£90
Total resource cost	0	-

3.4 NHS foundation trust code of governance disclosures

Statement

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

	Part of schedule A (see above)	Relating to	Code of Governance reference	Summary of requirement
1.	2: Disclose	Board and council of governors	A.1.1	The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.
The schedule of matters reserved for the board of directors was updated in 2015/16 following a detailed review of the trust's standing orders and standing financial instructions, and is published to the trust's website. This suite of documents was implemented from 1 April 2016. The schedule includes a series of statements detailing the roles and responsibilities of the council of governors. In 2016/17 separate standing orders for the council of governors were developed and adopted by council at its meeting on 20 October 2016. The trust's annual plan for 2013/14 described how any disagreements between the council of governors and the board of directors will be resolved and still stands. It is supported by the trust's constitution and standing orders (also published to the trust's website) to provide the framework for decision making and delegation between the board of directors, council of governors and executive management team.				
2.	2: Disclose	Board, nomination committee(s) audit committee, remuneration committee	A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors. Part of this requirement is also contained within paragraph 2.22 as part of the directors' report.
A register of this information is at section 7.1.				
3.	2: Disclose	Council of governors	A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.
A register of this information is at section 7.2.				
4.	Additional requirement of foundation trust annual reporting manual	Council of governors	n/a	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.
A register of this information is at sections 7.1 and 7.2.				
5.	2: Disclose	Board	B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.
A register of this information is at section 7.1.				
6.	2: Disclose	Board	B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.
Directors' biographies are included at section 7.3. The Trust considers that the board of directors remains balanced, complete, appropriate and compliant with the provisions of the NHS Foundation Trust Code of Governance and its own terms of authorisation.				

	Part of schedule A (see above)	Relating to	Code of Governance reference	Summary of requirement
7.	Additional requirement of foundation trust annual reporting manual	Board	n/a	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated.
8.	2: Disclose	Nominations committee(s)	B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.
See section 3.2				
9.	Additional requirement of foundation trust annual reporting manual	Nominations committee(s)	n/a	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.
Not applicable				
10.	2: Disclose	Chair/council of governors	B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.
A register of directors' interests is kept by the trust and is available at any time on request from the deputy company secretary. Since January 2016 the register has also been included in full in the papers for meetings of the board of directors held in public.				
11.	2: Disclose	Council of governors	B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.
The QVH annual plan for 2015/16 was presented at the annual members' meeting held on 25 July 2016, to which all members were invited. Regular information on strategy and development is included in the trust's newsletter for members and the general public and in email bulletins to members. Many governors take part in 'compliance in practice' sessions during which they engage with patients and members and provide feedback on their discussions.				
12.	Additional requirement of foundation trust annual reporting manual	Council of governors	n/a	If, during the financial year, the governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012).
Not applicable				
13.	2: Disclose	Board	B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.

	Part of schedule A (see above)	Relating to	Code of Governance reference	Summary of requirement
Following changes to the Trust's board-level governance structure and processes in 2015/16, the board undertook a review of effectiveness, publishing a report of its findings at its meeting held in public on 5 January 2017. It was satisfied that the changes to the structure of board sub-committees and frequency and timing of board level meetings were working well. In addition, with the introduction of a new style Board Assurance Framework launched in January 2016, the board has also continued to ensure that the organisation has a robust and effective risk management system. In preparation for the well-led review in 2017/18, the board undertook a governance and capability self-assessment in the second quarter of 2016/17. Whilst general satisfaction levels remained high in respect of strategy and planning, capability and culture, processes and structures and measurement, the board highlighted certain areas for improvement in 2017/18. This included additional clarity around plans to deliver strategy, stakeholder engagement, the Trust's vision, values and strategic goals and further work in respect of staff development, communication and empowerment. The performance of the executive directors is assessed by the chief executive, taking into account feedback sought from relevant members of staff and the board. The performance of the non-executive directors is assessed by the chair taking into account feedback sought from the executive directors and governors. The performance of the chair is assessed by the senior independent director in collaboration with the chair of the council of governors' appointments committee taking into account feedback sought from directors and governors, particularly the council's governor representatives to the board and its sub-committees. A review of the process of performance evaluation for directors and the chair took place in 2016, and changes were implemented to streamline existing procedures. It will continue to be refined on an annual basis to ensure input remains efficient and meaningful.				
14.	2: Disclose	Board	B.6.2	Where there has been external evaluation of the board and/or governance of the trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.
Not applicable				
15.	2: Disclose	Board	C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). See also ARM paragraph 2.92.
See the annual governance statement at section 3.7.				
16.	2: Disclose	Board	C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.
See the annual governance statement at section 3.7				
17.	2: Disclose	Audit committee/ control environment	C.2.2	A trust should disclose in the annual report: a. if it has an internal audit function, how the function is structured and what role it performs; or b. if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.
In 2016/17 the Trust's internal audit function was provided by Mazars Public Sector Internal Audit Limited; a subsidiary of Mazars LLP. The purpose of internal audit is to provide the trust board, via the audit committee, with an independent and objective opinion on risk management, internal control and governance arrangements. The scope of coverage in 2016/17 included: • financial systems and control • clinical governance, wards, business continuity • cyber security, estates management, health and safety, health records • board assurance framework and risk management.				

	Part of schedule A (see above)	Relating to	Code of Governance reference	Summary of requirement
18.	2: Disclose	Audit committee/ council of governors	C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.
Not applicable in 2016/17. At its meeting on 20 October 2016, the council of governors approved the re-appointment of KPMG as the Trust's external auditors for a three year reporting period.				
19.	2: Disclose	Audit committee	C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.

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

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

During 2016/17:

- The committee received reports from the Trust's internal and external auditors that provided the committee with a review of the Trust's internal control and risk management systems. The committee considered the key financial estimates when reviewing the financial statements.
- The committee undertook an annual review of its effectiveness and updated its terms of reference following the wider board-governance review. Its work programme is also reviewed during the last quarter of the financial year.
- The internal auditors were able to report full or substantial assurance for 70% of the areas reviewed, resulting in a head of internal audit opinion of significant assurance.
- Following an open procurement process, the council of governors, supported by the audit committee, appointed KPMG as the Trust's external auditors for a three year reporting period with effect from October 2016.
- The external auditors did not provide non-audit services.

The main source of income for the trust is the provision of healthcare services to the public under contracts with NHS commissioners. Given the materiality in value and the judgment used in relation to areas such as accruals for services not yet invoiced and partially completed spells, this has been identified as a risk in 2016/17. The Trust participates in the national agreement of balances exercise performed at months six, nine and twelve. The agreement of balances exercise identifies mismatches between receivable and payable balances recognised by the Trust and its commissioners and all differences are investigated by the finance team.

Trusts are responsible for ensuring that the valuation of their property, plant and equipment is correct and for conducting impairment reviews that confirm the condition of these assets. As a result of the suggested accounting policies provided by Monitor, trusts typically achieve this by performing an annual review for impairment, a periodic desk top valuation every three years and a full valuation in not more than five-yearly intervals. The Trust undertook a full valuation and impairment review during 2016/17.

	Part of schedule A (see above)	Relating to	Code of Governance reference	Summary of requirement
20.	2: Disclose	Board/ remuneration committee	D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.
Not applicable				
21.	2: Disclose	Board	E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.
The board of directors uses a variety of methods to understand the views of governors: • A governor representative attends all meetings of the board of directors in full (including seminars, workshops and meeting sessions held in private) and is an active participant. This representative is expected to provide feedback to governor colleagues, contributing to the council's statutory duty to hold non-executive directors to account for the performance of the board of directors • Directors attend all meetings of the council of governors held in public. In 2016/17 council meeting agendas continued to be refined to provide more opportunities for non-executive directors to report to the council and for dialogue between non-executive directors and governors generally. • The board invites a governor representative to attend meetings of its sub-committees to participate and feedback to governor colleagues. As the sub-committees are chaired by non-executive directors this facility gives more governors the opportunity to observe non-executive directors performing their duties as well as providing governors with wider insight into the operational activities of the trust and corporate governance. • The board of directors and council of governors have in place a document formalising principles of engagement between the council's governor representatives and the trust's board-level structures and mechanisms. • QVH's governor representative roles foster closer working relationships between governors and non-executive directors (NEDs) and provide more opportunities for governors to see NEDs at work on a regular basis. As a result, governors are better able to appraise the performance of the NEDs and hold them to account and NEDs are better informed of the views of governors and members. At its meeting on 19 January 2017, the council of governors undertook its annual review of collective performance with particular reference to › holding the non-executive directors individually and collectively to account for the performance of the board of directors, › communicating with their member constituencies and the public and transmitting their views to the board of directors and › contributing to the development of forward plans of NHS Foundation Trusts.			
22.	2: Disclose	Board/membership	E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.
The board recognises the challenges and limitations of establishing a representative membership base, as it serves a large regional population with a range of specialist services and a smaller local population with a range of community services. Nonetheless, it ensures it continues to meet its responsibility to engage with stakeholders through various means, including the regular scrutiny of Friends and Family Test and patient experience results. In recent months a QVH patient has been invited to each board meeting to describe their experience of care at the trust. The governor representative role continues to enable strong and direct engagement between governors and the board, especially non-executive directors. In 2016, the board reviewed QVH's membership base and extended eligibility for membership to the 12 south London boroughs in addition to the previous geography of Kent, Surrey and East and West Sussex. This review was aligned to the requirement for a public membership profile that most fairly enfranchises the people who are the recipients of the trust's services, and increased the total proportion of QVH patients eligible for membership from 94% to 98%.				
23.	2: Disclose	Membership	E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.
Members who wish to communicate with the directors or governors should contact the deputy company secretary on 01342 414200 or hilary.saunders@qvh.nhs.uk. This information is also available from the trust's website at: www.qvh.nhs.uk/about-us/board-of-directors and www.qvh.nhs.uk/for-members/council-of-governors-2				

	Part of schedule A (see above)	Relating to	Code of Governance reference	Summary of requirement
24.	Additional requirement of foundation trust annual reporting manual	Membership	n/a	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.
The Trust's members belong to either the public or staff constituency. Paragraphs 8 and 9 of the Trust's constitution set out eligibility criteria for membership of each constituency. As at 31 March 2017, the number of members within the public constituency was 7,480 and the staff constituency was 998. The Trust's membership strategy was reviewed by the trust and presented to governors and non-executive directors at the Trust's annual membership meeting on 25 July 2016. It is available online at www.qvh.nhs.uk/for-members/public-meetings				
25.	Additional requirement of foundation trust annual reporting manual (based on FReM requirement)	Board/council of governors	n/a	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report. See also ARM paragraph 2.22 as directors' report requirement.
A register of directors' and governors' interest is kept by the Trust and is available on request from the deputy company secretary.				
26.	6: Comply or explain	Board	A.1.4	The board should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery
Compliant				
27.	6: Comply or explain	Board	A.1.5	The board should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance
Compliant				
28.	6: Comply or explain	Board	A.1.6	The board should report on its approach to clinical governance.
The trust's clinical governance group is responsible for: • ensuring that QVH meets its statutory duty of quality through clinical governance • ensuring the best use of available resources for patients by establishing policies for effective clinical services • identifying and instigating policy improvement from clinical audit and outcomes monitoring processes • identifying and mitigating risks relating to the development and implementation of clinical policy. The group meets formally monthly and reports to the quality and governance sub-committee of the board which, in turn, provides assurance to the full board of directors. The group is chaired by the medical director and its members include the director of nursing, the head of risk, the governance leads of clinical specialties, senior nurses and service managers.				
29.	6: Comply or explain	Board	A.1.7	The chief executive as the accounting officer should follow the procedure set out by NHS Improvement (Monitor) for advising the board and the council and for recording and submitting objections to decisions.
Compliant				
30.	6: Comply or explain	Board	A.1.8	The board should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life
Compliant. The constitution is published to the website. The Trust's standards of business conduct and behaviour policy was revised and approved by the finance and performance sub-committee to the board in July 2016, and subsequently published. This policy was also disseminated to the council of governors at its meeting on 20 October 2016.				

	Part of schedule A (see above)	Relating to	Code of Governance reference	Summary of requirement
31.	6: Comply or explain	Board	A.1.9	The board should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility.
See 30 above				
32.	6: Comply or explain	Board	A.1.10	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors.
Compliant				
33.	6: Comply or explain	Chair	A.3.1	The chairperson should, on appointment by the council, meet the independence criteria set out in B.1.1. A chief executive should not go on to be the chairperson of the same NHS foundation trust.
Compliant				
34.	6: Comply or explain	Board	A.4.1	In consultation with the council, the board should appoint one of the independent non-executive directors to be the senior independent director.
Compliant. Lester Porter was appointed as the Trust's senior independent director in April 2014 in consultation with the council of governors.				
35.	6: Comply or explain	Board	A.4.2	The chairperson should hold meetings with the non-executive directors without the executives present.
Compliant. The chair has held monthly meetings with the non-executive directors throughout the course of 2016/17				
36.	6: Comply or explain	Board	A.4.3	Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes.
Not applicable in 2016/17				
37.	6: Comply or explain	Council of governors	A.5.1	The council of governors should meet sufficiently regularly to discharge its duties.
Compliant. The Trust's constitution stipulates that the council of governors should meet at least four times per year. During 2016/17 the council of governors held meetings in public on 21 April 2016, 25 July 2016, 20 October 2016 and 19 January 2017.				
38.	6: Comply or explain	Council of governors	A.5.2	The council of governors should not be so large as to be unwieldy.
The council of governors comprises 20 public members, three staff members and three stakeholder representatives, as established by paragraph 14 of the trust's constitution.				
39.	6: Comply or explain	Council of governors	A.5.4	The roles and responsibilities of the council of governors should be set out in a written document.
Compliant. NHS Improvement (Monitor) publishes guides to the duties and legal obligations of foundation trust governors. General duties of the trust's council of governors are included in provision 19 of the Trust's constitution.				
40.	6: Comply or explain	Council of governors	A.5.5	The chairperson is responsible for leadership of both the board and the council but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive to their meetings and inviting attendance by other executives and non-executives, as appropriate.
Compliant. Provision 20 of the Trust's constitution explains the arrangements in place for the Trust.				
41.	6: Comply or explain	Council of governors	A.5.6	The council should establish a policy for engagement with the board of directors for those circumstances when they have concerns.
Provision 52 of the Trust's constitution sets out provisions for disputes between the council of governors and board of directors.				

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

	Part of schedule A (see above)	Relating to	Code of Governance reference	Summary of requirement
51.	6: Comply or explain	Nomination committee(s)/ council of governors	B.2.5	The governors should agree with the nominations committee a clear process for the nomination of a new chairperson and non- executive directors.
The appointments committee is a sub-committee of the council of governors. Part of its remit is to oversee the appointment processes for the chair and non-executive directors, making recommendations in this regard to the council of governors. In 2016/17, a search for a non-executive director was initiated on behalf of governors by the appointments committee with the support of the Trust's human resources director and corporate affairs team. The candidate brief was developed in collaboration with the appointments committee, and was informed by a skills audit of existing non-executive directors undertaken by the Trust chair. The search, selection and nomination process is described in detail in papers put to the council of governors on behalf of the appointments committee on 2 February 2017. This appointment was formally noted in public at the council of governors meeting on 10 April 2017.				
52.	6: Comply or explain	Nomination committee(s)	B.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist of a majority of governors.
Compliant				
53.	6: Comply or explain	Council of governors	B.2.7	When considering the appointment of non-executive directors, the council should take into account the views of the board and the nominations committee on the qualifications, skills and experience required for each position.
The appointments committee's terms of reference state that before any appointment is made by the council of governors, it should evaluate the balance of skills, knowledge and experience of the non-executive directors and, in light of this evaluation, prepare a description of the role and capabilities required for a particular appointment. In 2016, following the departure of Ian Playford, a skills audit of existing non-executive directors was undertaken by the chair to map skills to the Trust's key strategic objectives and identify gaps. The results of the audit were used to develop and agree the candidate brief for the recruitment of a new non-executive director (see row 51 above).				
54.	6: Comply or explain	Council of governors	B.2.8	The annual report should describe the process followed by the council in relation to appointments of the chairperson and non- executive directors.
See row 51 above				
55.	6: Comply or explain	Nomination committee(s)	B.2.9	An independent external adviser should not be a member of or have a vote on the nominations committee(s).
Compliant				
56.	6: Comply or explain	Board	B.3.3	The board should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity.
Not applicable				
57.	6: Comply or explain	Board/council of governors	B.5.1	The board and the council governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make.
Compliant. Papers for meetings of the board of directors and council of governors are available from the Trust's website. In addition to meeting papers, the board of directors and council of governors receive regular briefings from the Trust, its regulators and its representative bodies to inform and provide context to the functions and decisions of the board and the council of governors. The council of governors receives notification when papers for meetings of the board of directors are published and the meeting agenda and chief executive's report are extracted from the papers and issued directly to governors. Governors have a facility to log general queries to non-executive directors and the Trust's executive management team. The log records the response to the queries so that they can be shared systematically with all governors to support understanding and learning across the council of governors. Governor representatives to the board and its sub-committees also submit personal reports to their colleagues in the monthly newsletter for governors.				
58.	6: Comply or explain	Board	B.5.2	The board and in particular non-executive directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis.
Compliant				

	Part of schedule A (see above)	Relating to	Code of Governance reference	Summary of requirement
59.	6: Comply or explain	Board	B.5.3	The board should ensure that directors, especially non- executive directors, have access to the independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors.
Compliant				
60.	6: Comply or explain	Board/committees	B.5.4	Committees should be provided with sufficient resources to undertake their duties.
Compliant				
61.	6: Comply or explain	Chair	B.6.3	The senior independent director should lead the performance evaluation of the chairperson.
The performance of the chair is assessed by the senior independent director in collaboration with the chair of the council of governors' appointments committee, taking into account feedback sought from non-executive directors, executive directors and governors. See row 13 above.				
62.	6: Comply or explain	Chair	B.6.4	The chairperson, with assistance of the board secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as board members.
Compliant. The board of directors meet every other month for a seminar which gives a greater focus on strategy development and opportunities for board development. The board development programme has been shaped to ensure that it operates effectively and that the organisation is well led. The programme is the responsibility of the Trust chair who is supported in this task by the director of human resources and organisational development and the head of corporate affairs.				
63.	6: Comply or explain	Chair/council of governors	B.6.5	Led by the chairperson, the council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities.
The collective performance of the council of governors was reviewed at its meeting on 19 January 2017. The report supporting this review is available online at www.qvh.nhs.uk/for-members/public-meetings Communication with members and the public on how the council has discharged its responsibilities is also provided in two annual newsletters and regular email communication with those members who have provided the Trust with their email address.				
64.	6: Comply or explain	Council of governors	B.6.6	There should be a clear policy and a fair process, agreed and adopted by the council, for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council or has an actual or potential conflict of interest which prevents the proper exercise of their duties.
The circumstances in which a governor may be disqualified or removed from the council of are set out in provision 18 of the Trust's constitution.				
65.	6: Comply or explain	Board/ remuneration committee	B.8.1	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.
Not applicable				
66.	6: Comply or explain	Board	C.1.2	The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary. See also ARM paragraph 2.12.
See section 2.1				

	Part of schedule A (see above)	Relating to	Code of Governance reference	Summary of requirement
67.	6: Comply or explain	Board	C.1.3	At least annually and in a timely manner, the board should set out clearly its financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance.
Compliant. The board sets out clearly its financial quality and operating objectives for the Trust through board papers, published to the website. These include both quantitative and qualitative information on the Trust's business and operation. Clinical outcome data is included in the annual quality account.				
68.	6: Comply or explain	Board	C.1.4	a) The board of directors must notify NHS Improvement and the council of governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS foundation trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS foundation trust. b) The board of directors must notify NHS Improvement and the council of governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in: • the NHS foundation trust's financial condition; • the performance of its business; and/or • the NHS foundation trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS foundation trust.
Compliant				
69.	6: Comply or explain	Board/audit committee	C.3.1	The board should establish an audit committee composed of at least three members who are all independent non-executive directors.
Compliant				
70.	6: Comply or explain	Council of governors/audit committee	C.3.3	The council should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors.
Compliant. The council approved the re-appointment of the Trust's external auditors at its meeting held in public on 20 October 2016. The contract is for a period of three years with an option to extend for a further two years.				
71.	6: Comply or explain	Council of governors/audit committee	C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust.
The Trust's external auditor was originally appointed in August 2011, and following a transparent and competitive process was reappointed in October 2016 (see 70 above).				
72.	6: Comply or explain	Council of governors	C.3.7	When the council ends an external auditor's appointment in disputed circumstances, the chairperson should write to NHS Improvement informing it of the reasons behind the decision.
Not applicable				

	Part of schedule A (see above)	Relating to	Code of Governance reference	Summary of requirement
73.	6: Comply or explain	Audit committee	C.3.8	The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.
In 2016/17, Mazars acted as providers of the Trust's local counter fraud specialist service. An annual work plan was agreed and delivery was overseen by the audit committee. Counter fraud policies and procedures are widely publicised for staff and are included as part of the new staff induction process. Whistleblowing is the responsibility of the quality and governance committee. However, the audit committee is responsible for providing assurance that the whistleblowing process is fit for purpose and working effectively, as required by the board. The process to appoint a Freedom to Speak up Guardian commenced in March 2017 with the appointment confirmed in April 2017.				
74.	6: Comply or explain	Remuneration committee	D.1.1	Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels.
Compliant				
75.	6: Comply or explain	Remuneration committee	D.1.2	Levels of remuneration for the chairperson and other non- executive directors should reflect the time commitment and responsibilities of their roles.
Compliant				
76.	6: Comply or explain	Remuneration committee	D.1.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination.
Not applicable				
77.	6: Comply or explain	Remuneration committee	D.2.2	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments.
Compliant				
78.	6: Comply or explain	Council of governors/ remuneration committee	D.2.3	The council should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.
Compliant. Following publication of the 2015 remuneration survey by NHS Providers, the appointments' committee reviewed the remuneration and terms and conditions of the chair and non-executive directors, and made recommendations in this regard to the council of governors at its public meeting on 25 July 2015.				
79.	6: Comply or explain	6: Comply or explain Board	E.1.2	The board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums.
Compliant				
80.	6: Comply or explain	Board	E.1.3	The chairperson should ensure that the views of governors and members are communicated to the board as a whole.
Compliant. Responsibility for ensuring that the views of governors and members are communicated to the board as a whole is shared between the chair, the head of communications and corporate affairs and the governor representative to the board of directors.				

	Part of schedule A (see above)	Relating to	Code of Governance reference	Summary of requirement
81.	6: Comply or explain	Board	E.2.1	The board should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co- operate.
In 2016/17 the board of directors continued to spend a significant amount of its time considering and developing its relationships with: • NHS trusts which host QVH 'spoke' services across the South East region • Brighton and Sussex University Hospitals in relation to burns services, major trauma services and head and neck cancer surgery • Horder Healthcare, which shares the Trust's site in East Grinstead and provides private healthcare as well as some NHS services. The board of directors recognises that co-operation and collaboration are key to the sustainability of the organisation and ways in which it ensures this include: • QVH sits within the footprint of the Sussex and East Surrey Strategic Transformation Plan (STP). We also treat a significant number of patients from Kent and therefore we are staying closely involved with the Kent and Medway STP. In 2016/17 all members of the executive team participated in relevant functional groups and continue to ensure the QVH plays a full part in this collaborative work. • That executive management team and their direct reports (on behalf of the board) are responsible for maintaining collaborative and productive relationships with representatives of third parties. They are supported by members of the clinical cabinet. • Third-party developments and opportunities are reviewed by the executive management team at its weekly meetings and take into account views and advice sought from the clinical cabinet and leadership forum. • Issues and risks are reported to the relevant groups/committees within the Trust's governance structure and escalated to the board of directors for oversight and scrutiny.				
82.	6: Comply or explain	Board	E.2.2	The board should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each.
Compliant. See row 81.				

3.5 NHS Single Oversight Framework

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

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

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

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's Risk Assessment Framework (RAF) was in place. Information for the previous year and first two quarters relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Segmentation

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

This segmentation information is the Trust's position as at 7 April 2017. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the trust disclosed above may not be the same as the overall finance score here. The table below details the use of resources score for the last two quarters of the 2016/17 financial year.

Area	Metric	2016/17 Q3 score	2016/17 Q4 score
Financial sustainability	Capital service capacity	1	1
	Liquidity	1	1
Financial efficiency	I&E margin	1	1
Financial controls	Distance from financial plan	1	1
	Agency spend	3	3
Overall scoring		**1**	**1**

The Trust's overall score is 1; the highest score possible. A score of 1 was also achieved in 4 out of the 5 individual metrics with the single exception being performance on agency spend. This metric measures performance against an agency spend target, as set by NHS Improvement. The Trust was unable to achieve the target due to recruitment issues in areas of national shortage, the requirement for increased capacity and to deliver performance targets.

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

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

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

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

Steve Jenkin
Chief Executive
25 May 2017

3.7 Annual governance statement

Scope of responsibility

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

The purpose of the system of internal control

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

The system of internal control has been in place in Queen Victoria Hospital NHS Foundation Trust for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Risk management is a corporate responsibility and the board of directors ensure that effective processes are in place to manage risk. The board is committed to the continuous development of a risk management framework focused on preventing harm to patients, staff and the public and to protect the Trust from losses or damage to its reputation.

The director of nursing is the Trust's lead for risk, supported by the head of risk. The Trust's quality and governance committee oversees the systems and processes in place for risk management and the clinical governance group is responsible for the management and monitoring of risk management in the organisation. The quality and governance committee is chaired by a non-executive director. At every public trust board there is a detailed quality report which incorporates risk management and a report from the chair of the quality and governance committee to provide assurance about the risk management. The board assurance framework and the corporate risk register are also reviewed in full at every public trust board to facilitate discussion about the level of risk, mitigating actions and gaps in controls to sustain and improve performance against fundamental standards of quality and safety. The board assurance framework details the risks to achieving the organisation's five key strategic objectives. Each of these objectives has a lead director responsible for reviewing the risk, as a minimum, bi-monthly using the risk assessment matrix and ensuring systems and processes are in place to mitigate the risk fully or partially.

The Trust's risk management and incident reporting policy has been rewritten during 2016 following consultation with trust staff, internal and external auditors. It is published on the Trust intranet and is available to all staff. Staff receive mandatory and, where required, bespoke training to facilitate risk management at all levels in the organisation. In September 2016 the risk team undertook 'Safetember' which was designed to raise the profile of risk management and support the translation of risk management policy into actual practice. Risk management training is also a mandatory requirement for all new staff joining the Trust and forms part of the initial induction programme.

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

The Trust has invested in human factors training during 2016/17 which is being led by the medical director to facilitate a safety culture and ensure learning from incidents is shared throughout the whole organisation.

Key strategic objectives

Key strategic objective	Risks	Mitigation	Evidence of outcome
Outstanding patient experience. *We put patients at the heart of safe, compassionate, competent care provided by well-led teams in an environment that meets the needs of patients and their families.*	The principle risk to delivery of this objective is the ability of the Trust to recruit and retain the right staff with the specialist skills required for caring for all our patients, especially in theatres and critical care. Factors influencing this risk include: Large numbers of vacant nursing posts in Sussex, east surrey and Kent National shortages of specialist nurses specific impact in theatres and critical care Impact of Brexit on workforce Removal of nursing bursary, which has had a negative impact on number s of nursing applications Loss of confidence in the quality of services and the environment in which we provide them, due to the condition and fabric of the estate.	Bespoke specialty recruitment days and advertisements Increasing student placements available at QVH Meet students at recruitment days prior to them graduating Supporting return to practice students Review of remuneration for substantive and bank staff Consideration of European and International recruitment Bursary issue raised with the chief nursing officer for England and the secretary of state, no changes planned to government policy Development of full estates strategy, programme of maintenance and remedial work in progress. Partnerships with neighbouring trusts. Investment in posts to support quality, compliance, audit and research. Focus on placement experience and improved supervision for trainees Demonstrating compliance with CQC essential standards Plans to audit 20% of applicable NICE clinical guidelines and quality standards Out-of-hours review of medical workforce	Increased applications and appointment of appropriately qualified staff Additional student placements agreed with the university Attendance by director of HR and deputy director of nursing at February Brighton university campus event Placements available for return to practice nurses and operating department practitioners. Workforce efficiency group reviewing substantive and bank nurses pay, proposals to be presented to executive management team Decision on European and international recruitment made by executive management team
World class clinical services. *We provide a portfolio of world class services that are evidenced by clinical and patient outcomes and underpinned by our reputation for high quality education and training and innovative research and development.*	As a stand-alone specialist surgical hospital, the absence of co-located general medical, paediatric and diagnostic services puts pressure on the ability of the Trust to provide a safe and effective out-of-hours service. There is a risk of loss of confidence in Trust services due to a lack of published outcomes, reduction in research outputs, fall in teaching standards or delivery of the required clinical governance standards across all sites of delivery.	Partnership working and robust service level agreements with neighbouring trusts. A growing relationship with the STP and BSUH to provide safe, sustainable services. Review and audited adherence to relevant National standards, including NCEPOD, CQC, NICE, Seven Day Services, Clinical Governance and Mortality Reviews and Learning. Robust local clinical governance programmes, reporting through a defined pathway to the board of directors. Quality, audit and research strategies and action plans. Quality assured medical staff appraisal and revalidation systems.	QVH contribution to STP planning at all levels. Separate workstreams with BSUH to develop shared pathways in plastic, burns and maxillofacial surgery. Quality account details evidence of clinical outcomes measurement and clinical audit. Increased contribution to national portfolio research studies. Quality and governance committee overseas local governance programmes. Appraisal and revalidation systems assessed by NHS England.

Key strategic objective	Risks	Mitigation	Evidence of outcome
Operational excellence. *We provide streamlined services that ensure our patients are offered choice and are treated in a timely manner.*	The principle risks to delivery of this objective are the time needed for complex diagnostics in our more specialist work and the timeliness of referrals from partner trusts. Related risks include: • Loss of confidence in ability to provide timely and effective treatment due to increase in waiting times and/or fall in productivity. • The key issues and risks for the Trust in delivering this objective is that very small shifts in either demand or capacity have a significant impact on referral to treatment and cancer waiting time performance. Also, many of our patients require complex diagnostic pathways due to the specialist nature of our work and so this lengthens the treatment pathway. Several of our neighbouring trusts and spoke sites are either in special measures or recently out of special measures and all have demand and capacity issues. This often results in late referrals to us.	This is mitigated by regular contact with other Trusts to improve processes for joint pathways. Proactive tracking of patients alongside robust demand, capacity & pathway planning. Where capacity demonstrates the need, business cases are submitted to gain the additional resources to manage demand. Monthly performance review and reporting to finance and performance committee.	Contract meetings in place and pathways discussed and remedial action taken e.g. increasing Mohs skin cancer surgery contract from 2017/18 to manage increasing referrals. Our backlog of patients over 18 weeks is steadily decreasing against a backdrop of increased clock starts. This demonstrates that we are booking patients in chronological order, that the tracking of patients to manage delays is working and will help to put us in a sustainable position going forward. Successful delivery of the 6 week diagnostic wait element of the target. Successful business cases submitted for additional consultant workforce.
Financial sustainability. *We maximise existing resources to offer cost-effective and efficient care whilst looking for opportunities to grow and develop our services.*	The wider challenges to NHS finances and the uncertain policy environment coupled with significant internal efficiency targets and recruitment concerns put pressure on the Trust's ability to maintain past performance and achieve future targets. Loss of confidence in long-term financial sustainability due to failure to create adequate surpluses to fund operational and strategic investments.	Close collaboration with partners and regulators, robust and effective planning are key to delivery. Robust contract monitoring and monthly performance review. Development of achievable and sustainable cost improvement plan. Enhanced budget setting and business planning. Structure, systems and process redesign and enhanced cost control.	Contract monitoring framework in place, supported by strong engagement and due diligence processes. Introduction of new programme management office to support the delivery of cost improvement and productivity plans. Implementation of a business planning framework that supported delivery of both the overall financial targets and cost improvement and productivity programme delivery in excess of the 2016/17 target. Restructures completed in a number of functional areas; coupled with system/process reviews designed to facilitate more effective working across the wider Trust.
Organisational excellence. *We seek to maintain and develop a strong professional and caring culture through clear standards, high expectations and exemplary leadership*	The principle risk to delivery of this objective is the ability of the Trust to recruit and retain staff, particularly in critical care and theatres. Use of temporary and agency staff impacts on job satisfaction and may impact quality of care. The related risk is loss of staff confidence in the trust as place of choice to work and a good employer.	Three-year workforce plan for 2017-2020. New leadership and management development programme, board approved staff survey action plan. Support for staff education and learning. Engaged in NHS Employers national retention initiative. This will be a key area of work in 2017/18.	Investment in e-workforce solutions. Increased focus on retention projects. Increased focus on organisational development, particularly staff engagement and communication.

The risk and control framework

The Trust risk management strategy was re-written in 2016/17. The strategy covers a four year period with annual reviews planned. This strategy outlines the framework within the Trust governance structure and the requirements for individuals and teams to comply with key regulatory instructions and legislation, to manage risk effectively and contribute to achieving the Trust's key strategic objectives.

The Trust's risk management and incident reporting policy provides an outline of the risk processes and the ways in which a risk should be assessed, actioned and escalated. It also defines the difference between incidents and risks. The Trust's risk assessment tool includes a 5 x 5 matrix to determine the level of risk based on likelihood x consequence and requires the assessor to identify hazards, existing controls and further controls required. All staff must complete mandatory risk management training. Incidents can be logged directly by the individual on the Trust risk management system or via their line manager. A risk can be raised primarily by the individual speaking to their line manager or risk manager. There is also provision for staff to raise a risk confidentially or anonymously via the director of nursing's confidential 'Tell Jo' email account or using the Trust whistleblowing process.

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

A range of data and risks are managed via the trust risk management software package, these include, incidents, complaints, claims, CQC standards and freedom of information requests. The software allows risks, incidents complaints and claims to be linked and interpreted to look for trends and areas of concern. This system is managed by the risk team but the reports generated form part of the governance and business unit agendas.

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

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

- The public trust board meetings are held bimonthly, there are detailed reports which include all key national performance measures on quality, performance finance and workforce. There is opportunity for robust challenge and debate about these reports and the way in which the directors work collaboratively in order to meet the trusts key strategic objectives and provide leadership and oversight of the systems in place for care provision and service delivery. In addition to this governance process, the non-executive chair of each board committee presents a report to the board about the level of assurance and key items for approval or discussion. All actions are monitored via a board action log.
- The quality and governance committee and the finance and performance committee, both committees of the board, have met monthly. Directors present detailed reports on quality, performance, finance and human resources and there is an opportunity for scrutiny and challenge of these reports prior to them being presented at public trust board by the non-executive directors. Both committees monitor completion of actions via a committee action log.

- The audit committee seeks additional assurance on risk management by commissioning internal and external audits as part of the audit work programme or in response to specific issues. The board follows the principles of the Monitor quality governance framework in assessing and determining the assurances required and designing the audit work programme.
- Full presentation of the board assurance framework and corporate risk register at every public trust board.
- Timely response to NHS Improvement information and monitoring requests and executive management team attendance at the quarterly NHS Improvement performance reviews.
- Monthly submission to the Care Quality Commission (CQC) of performance against fundamental standards and completion of the 2016 CQC inspection action plan.

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

Risk management is embedded within the activity of the organisation in many ways. For example, risk management is included within each departmental meeting agenda and existing risks are discussed along with the identification of new risks. Staff are actively encouraged to report incidents and near misses to identify potential risks and take action to prevent this. Learning from incidents is integral to the risk process and is shared at a variety of forums and groups including the clinical governance group, quality and governance committee, the weekly staff newsletter and the joint hospital governance group. The clinical governance group monitors all clinical incidents to ensure action identified are completed and learning is shared. Examples of changes as a result of the learning in 2016/17 include changes in clinical practice, bespoke training sessions and amendments to Trust policy.

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

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

Queen Victoria Hospital is fully compliant with the registration requirements of the Care Quality Commission (CQC) following a full inspection and unannounced follow-up visit during November 2015.

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

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

The Trust has undertaken risk assessments and 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

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

The financial plan for 2016/17 was approved by the board and submitted to NHS Improvement as required. Performance against the plan, any variations and remedial actions are examined at executive-led performance reviews and to an executive management meeting for oversight and scrutiny. Furthermore, reports including forecast projections, performance indicators and supporting narrative are presented at a monthly finance and performance committee and bi-monthly to the Trust board for assurance purposes.

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

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

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

During 2016/17, the Trust has performed well against the internal cost improvement and productivity challenge; exceeding planned expectations. In response to the challenge to deliver year-on-year improvements, the Trust has invested in a programme management office which is functionally responsible for driving the end-to-end process of identification, implementation and evaluation of cost improvement, productivity and business development initiatives across the Trust. The finance and performance committee receives monthly updates on programme performance whilst the quality and governance committee reviews plans to ensure there is no negative impact upon the quality of service provision and/or outcomes. The focus for 2017/18 will include further development of the programme management office and ensuring that the new ways of working are shared and embedded.

Information governance

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

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

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

During 2016/17, priority has been given to cyber security and in particular addressing any threats to our systems, processes and data. Intelligence has been used to create an action plan which includes ensuring all staff and volunteers are formally trained and tested on their understanding of the importance of handling data securely.

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

There were no serious incidents that were classified as a level 2 relating to information governance in 2016/17.

Annual quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on 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.

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

In response to the limited assurance opinion from last year's quality report, the Trust prioritised the appointment of a patient access and performance manager to lead a review and redesign of 18-week referral to treatment and 62-day cancer waits. However, this post has proved difficult to recruit to and so has been and is still (at the time of writing) covered by an interim.

Work is ongoing to review and redesign the cancer patient tracking list, refresh systems and processes to track and validate patients and refresh the training offered to staff.

The issue of data quality at our spoke sites remains a challenge for QVH. Work is underway to improve the quality of all externally supplied data. Whilst we are confident that this will lead to a significant improvement in data quality, the absence of a full year's data will result in the external auditors being unable to give QVH an unqualified opinion for 2016/17.

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

- Quarterly updates to the quality and governance committee on progress against quality priorities chosen for the quality account 2016/17
- Members of the clinical governance group, committees of the board and clinical cabinet receive performance reports on quality and performance metrics including infection control rates, referral to treatment performance, cancer waits, and patient experience measures
- National statutory data collected from external sources, which enables benchmarking and comparison with peers
- Specialty data compiled in conjunction with clinical directors and lead clinicians
- Specialty information/audit and national audit outcome data received by the clinical governance group
- External audit commissioned before submission to ensure data accuracy and validity.

Review of effectiveness

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

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

- Regular board review of the board assurance framework and risk registers, as well as regular assurance reports by the chairs of the two key board assurance sub-committees (finance and performance and quality and governance) and minutes from audit committee meetings. Key risks are fully debated and the board ensures actions are in place where necessary.
- Board members receive monthly performance reports on:
    - safe staffing and quality of care
    - operational performance
    - financial performance
    - workforce.
- The board receives regular information governance reports.

- The audit committee reviews findings from internal and external audit work and ensures links to the risk register and assurance framework are maintained.
- The head of internal audit opinion has given a 'significant assurance' rating on the effectiveness of the systems of internal control.
- The quality and governance committee reviews feedback from external assessments on quality of service, including NHS Improvement, Healthwatch, CQC, NHSLA and audit, as well as ensuring internal quality measures are regularly tested and standards are met.

Conclusion

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

Steve Jenkin
Chief Executive and Accounting Officer
25 May 2017

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Quality Report 2016/17

"Our quality priorities for 2017/18 are built around our ambitions to deliver safe, reliable and compassionate care in a transparent and measurable way."

Statement on quality

Queen Victoria Hospital (QVH) is a leading specialist centre providing life-changing reconstructive surgery, burns care and rehabilitation services for people across the South of England. Our expert clinical teams are also able to provide treatment for more common conditions for the people of East Grinstead and the surrounding area.

In 2016/17 there was considerable national celebration of the pioneering plastic surgery techniques developed at the hospital, some of which are still in use today, linked to the 75th anniversary of The Guinea Pig Club. Named after the experimental treatment given to airmen who sustained burns in World War Two, the camaraderie and shared experiences of The Guinea Pig Club's members helped them to support each other during their lengthy and painful rehabilitation. QVH is still at the forefront of the psychosocial aspects of burns healing as well as surgery.

Current research at Queen Victoria Hospital includes the clinical trials of a smart bandage which changes colour when it detects infections. We are also working towards improved healing for the millions of people affected each year by scarring, through the careful processing and storage of scar samples which will provide a resource to analyse how scars are formed.

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

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

Working with academic and technical partners we are developing 'smart specs' for people suffering facial palsy. Miniaturised sensors in the frames of the glasses measure facial symmetry by tracking the movement of muscles, and the intensity of those movements, giving feedback through a smart phone or tablet. This could transform the ability of both clinicians and patients to monitor their progress, as well as significantly increasing recovery as patients are more motivated to practice facial movements. This is just one example of the innovation and collaboration for which we are known.

Maintaining high quality services requires continual day-to-day improvements alongside longer term strategic developments. In 2016/17 we made good progress against our quality priorities which included reducing the investigation time for incidents, auditing our compliance with NICE guidelines and resurfacing the covered walkways around the hospital.

Looking to the future, I am confident that we have the necessary plans and processes in place to further improve patient safety and clinical effectiveness, and that our excellent teams of staff will continue to provide outstanding care.

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

Steve Jenkin
Chief Executive

Priorities for improvement and statements of assurance from the board

QVH's quality priorities for 2017/18

Our quality priorities for 2017/18 are built around our ambitions to deliver safe, reliable and compassionate care in a transparent and measurable way. They have been developed in collaboration with staff and the council of governors, and take in account progress on our 2016/17 priorities and patient feedback.

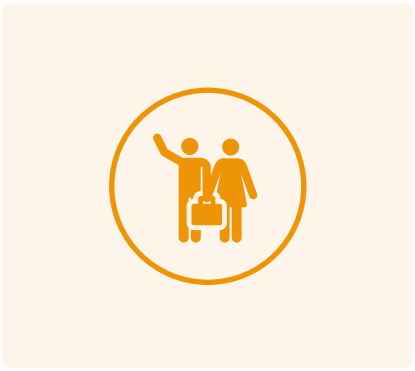
Each priority relates to one of the three core areas of quality:

Patient safety

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

Clinical effectiveness

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



Patient experience

Meeting our patients' emotional as well as physical needs.

"QVH is a surgical hospital.... Using our theatres efficiently and effectively is key"

Priorities for improvement

Our quality priorities and why we chose them	What success will look like
Patient safety	
Increased theatre productivity QVH is a surgical hospital and our operating theatres are critical for treating and caring for our elective and trauma cases. Using our theatres efficiently and effectively is key to reducing waits for treatment, reducing cancellations and making best use of NHS money. It is also important for patient experience and staff morale.	While there will always be some operating lists where start time is delayed, for example if a clinician urgently needs to attend to a seriously unwell patient on the ward, QVH has set internal targets for theatre start times. The QVH target for elective lists starting within 15 minutes of the booked start time is: • Q1 70% • Q2 75% • Q3 80% • Q4 85% The start of an operation is defined as the moment when the anaesthetic is administered, or 'needle to skin' time. Data will be produced daily in relation to late start times and reasons, and we plan to show a quarterly decrease in late theatre starts on the theatre dashboard.
Clinical effectiveness	
Mouth Care Matters This is an initiative to help improve the oral health of all of our inpatients and will run at QVH for one year. It will raise awareness of the links between oral health and general health, and ensure that patients' mouth care is being looked after and recorded in the notes for all inpatients. A baseline audit was carried out in November 2016 to assess current oral health practice and protocols at QVH. These findings showed that mouth care was not sufficiently recorded in the patient's notes, and there was low staff awareness of the importance of oral health for patients. To support this initiative, a programme of mandatory mouth care training sessions have been scheduled throughout the year for nursing assistants, nurses and other staff involved in the provision of mouth care.	The programme involves four audits. **Audit 1** will assess whether mouth care is being recorded in patient notes. **Audit 2** will measure patient feedback on the current level of mouth care on our wards, to see if anything can be improved. **Audit 3** is a written questionnaire undertaken every six months to seek the views of nursing staff on mouth care, including suggestions for improvements. **Audit 4** will be carried out quarterly to assess whether the newly implemented mouth care recording pack is being used and whether any improvements can be made. QVH will target a quarterly improvement in the findings of audits 2 and 4 showing mouth care being recorded in patient notes and improvements being made to our current oral health practice to the benefit of patients. We are also seek a quarterly increase in staff confidence in providing mouth care to our patients and understanding of the importance of good oral health in relation to the patient's general health. This will be measured through the nursing feedback questionnaire and training course evaluations.
Patient experience	
Improving patient experience in outpatients Last year patients attended 173,500 outpatient appointments at QVH and it is important to us that this should be a positive experience. We are continuing to work on initiatives that will make the waiting time shorter and each waiting area is being reviewed to ensure that when waits are unavoidable, patients are made as comfortable as possible and kept informed.	By the end of 2017/18 there will be designated paediatric waiting areas within outpatients, improved vending facilities and an improved waiting environment. We also aim to reduce waiting times in clinic, improve clinic utilisation and reduce the amount of rebooking of appointments due to hospital and patient cancellations.

Performance against 2016/17 quality priorities

Our quality priorities for 2016/17 were influenced by information from national and local reports and audit findings, along with the views of governors, patient feedback and suggestions from staff across the organisation.

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

Our quality priorities and why we chose them	What we said success would look like	Did we achieve it in 2016/17
Patient safety		
Reduce the investigation time for incidents from an average of 60 days to 30 days, in line with national targets to improve safety and learning from incidents We wanted to improve the time taken to report all incidents to the National Reporting and Learning Service (NRLS) by decreasing the number of days it takes us to do this.	QVH has set local targets to exceed the national recommendation of investigating incidents within 30 days. Incidents categorised as 'no harm', 'near miss' and 'minor harm' will be reported consistently within 10 working days in 90% of cases. Those incidents causing 'moderate', 'major' and 'catastrophic harm' will be reported within 20 working days in 80% of cases.	This has been achieved. Work is ongoing to provide additional staff training so that we have more staff who are confident and capable incident handlers and investigators.
Clinical effectiveness		
Proactive audit of compliance with 20% of applicable NICE clinical guidelines and quality standards QVH is committed to ensuring that services take into account national guidance and embed the latest evidence-based practice into the care and treatment of our patients. We chose to review 20% of our key National Institute of Health and Care Excellence (NICE) guidelines to measure compliance with their recommendations and identify any areas that require focussed attention or improvement.	From 2001 until March 2016, NICE published 21 quality standards and 44 clinical guidelines relevant to our services. Clinical audit projects will be completed for a minimum of 20% of these quality standards and clinical guidelines.	A total of 13 NICE clinical guidelines and four quality standards were audited as part of this work stream. A number of other audits were also undertaken across QVH, which measured the standards set out by NICE. Audits of high priority guidelines and quality standards were undertaken. Examples include pressure ulcers; inpatient falls; diagnostic tests before surgery; prevention of hypothermia after surgery; patient experience; domestic violence and safeguarding; and preventing infections after surgery in the part of the body where the surgery took place.
Patient experience		
Improve signage and walkways While patients tell us that the standard of care they receive across our services is very high, and they praise staff for the kindness and compassion they receive, some patients comment that they have difficulty finding departments and navigating the site. We chose to make it a priority to improve wayfinding for patients and visitors.	By the end of quarter two, improvements to the covered walkway surfaces will have been completed. In addition to resurfacing, we will ensure that the walkways meet dementia standards. We will remove obsolete signs and re-post as appropriate. In addition, a wayfinding strategy will be included within the estates improvement plan and any future estates developments will include wayfinding options.	At the end of quarter four, we completed work on developing a wayfinding strategy to improve access and make navigation easier. We involved patients, visitors, volunteers, front-line and support staff including our dementia lead. The result is a clear long-term solution covering signage, appointment letters, web based information and other journey planning tools. Once rolled out this will help reduce stress and anxiety, enhance the overall patient experience and better meet the current and future needs of the site. In addition we have made improvements to covered walkways including new floor surfaces to meet dementia standards.

Safeguarding

Safeguarding Children
'The welfare of the child is paramount' principle was enshrined in the Children Act 1989 and has driven the development of systems and arrangements used to safeguard and/or protect children since that time. Section 11 of The Children Act 2004 places a statutory duty on all NHS organisations to ensure that services are designed to safeguard and promote the welfare of children.

Safeguarding Adults
The arena for safeguarding adults has changed dramatically since the implementation of the care act 2014. As an organisation, QVH follows the Sussex Safeguarding Adults policy and procedures document, as this provides us with an overarching framework to coordinate all activity undertaken where a concern relates to an adult experiencing or at risk of abuse or neglect.

Modern Slavery Act 2015
The Modern Slavery act received royal assent during March 2015, it encompasses human trafficking, forced labour and domestic servitude. There is an increased awareness around the modern slavery arena within QVH. There is a trust protocol so staff can familiarise themselves with identifying and supporting victims of modern slavery. There have been cases identified within the trust where staff have managed and referred victims for ongoing help and support.

> "QVH prides itself on patient centred care and the safeguarding agenda is part of this,"

QVH is committed to ensuring the protection, safety and wellbeing of vulnerable children and adult patients and their families who attend to QVH. Safeguarding our patients is part of our everyday practice at QVH.

Over the last year a range of activities have been undertaken to enable staff to provide effective safeguarding and to keep patients informed about why we do things and how they can obtain help and support.

Safeguarding children principles are well embedded in the organisation. This means that staff raise awareness of any concerns they may have about a child or young person. The concerns are carefully considered, discussed with the family and, if required, referred to other agencies and/or community health services so that the child and family are supported and protected.

QVH staff also work with children and their families to help them understand what is required or expected of them, and participate in social care discussions, which often require them to write reports about a given situation.

The safeguarding team are available to support staff to work safely, sensitively and effectively with all patients, and strive to find constructive ways to address any concerns that are raised. We also have designated safeguarding link staff in place across all services, who are on hand to provide advice and support for colleagues.

Partnership working
The QVH safeguarding team work closely with West Sussex Safeguarding Children Board and West Sussex Safeguarding Adults Board to ensure that priorities are addressed and to enable effective joint agency working at all levels of service delivery.

Our safeguarding team undertook a review of QVH's safeguarding accountability and governance structures, and have introduced new patient care systems. These help to identify those patients who may have been forced into modern day slavery or are victims of female genital mutilation or becoming radicalised. Our paediatric safeguarding named nurse is the child sexual exploitation lead for the organisation and is pivotal in identifying potential victims.

QVH works with other providers to ensure that children who regularly attend our minor injuries unit or other emergency units can be supported by health care professionals and other agencies for any safeguarding issues previously raised. This includes managing the issues sensitively, safely and effectively.

If a patient attends QVH with a dog bite injury information is routinely passed to the police who will decide if there is any further support or discussion required with the person who was injured. In order to be transparent with our patients, the safeguarding team have produced QVH patient leaflets for sharing information about dog bite injuries.

We also monitor and respond to instances of children not being brought to appointments, so that we can work with parents and carers to ensure medical treatment and health care is completed in a timely way for all children who are patients at QVH.

Responding to and supporting those patients who experience domestic abuse and violence is key to protecting them and stopping the violence. QVH has a policy and procedures in place to enable staff to work effectively with those who might be injured and requiring specialist interventions. We also offer support to employees affected by domestic abuse as part of QVH's commitment to developing a workplace culture in which there is zero tolerance of abuse.

Prevent
Prevent is the Government's strategy to stop people becoming involved in violent extremism or supporting terrorism, in all its forms. Prevent works within the non-criminal space, using early engagement to encourage individuals and communities to challenge violent extremist ideologies and behaviours. The Home Office 'Prevent Strategy' is linked to the safeguarding agenda. QVH sits in a 'priority area' and so has close working links with other local healthcare organisations, NHS England and the local clinical commissioning group.

Training for staff
High quality training for all QVH staff helps us to respond to all safeguarding concerns swiftly and effectively. The level of training provided is dependent on individual job roles, and their level of interaction with patients, and children. QVH prides itself on its high training attendance and resources available to support staff knowledge.

We have also been working with partner trusts to enable acute sector staff to attend relevant level 3 training.

During 2016, QVH implemented the national Home Office approved training workshop to raise awareness of Prevent (WRAP 3) across the Trust, and 75% of relevant staff have attended.

Safeguarding governance arrangements at QVH have become more robust during the last year. QVH prides itself on patient centred care and the safeguarding agenda is part of this, including continuously striving to develop and support staff to achieve best outcomes for the patient and promoting a culture where we all feel able to raise concerns.

Sign up to Safety campaign

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

In 2015, when we used the Manchester Patient Safety Framework to help assess our progress in developing a safety culture, staff felt that feedback from reported incidents could be improved. The QVH incident reporting system now gives reporters the option to receive feedback if they wish. If selected, a copy of the investigator's report is automatically sent to the reporter when the incident is closed.

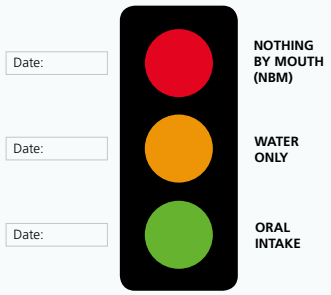
We have also put in place a number of improvements to our risk management processes. For example, dedicated QVH leads for health and safety, medical devices, COSHH and human factors have been identified along with manual handling link workers to assist with managing safety at a departmental level.

We also undertake detailed monitoring of incident reporting by staff and are working to reduce investigation timescales with a target of completing investigations within 30 days for all incidents. Incidents, risks, claims, complaints and audits are now triangulated, with information fed into monthly performance monitoring meetings.

We have enhanced the support and learning available for staff with the creation of a new Datix users forum, additional risk management training and information shared through the weekly staff newsletter. Issues for learning are discussed at a range of forums across QVH and at morbidity and mortality meetings, and learning from incidents is part of all business unit governance meetings.

Our Sign up to Safety pledges can be viewed on our website at **www.qvh.nhs.uk/for-patients/sign-up-to-safety-pledges/**

Patient safety achievements

2016/17 achievements	Further work for 2017/18
Traffic light system for oral intake Reconstructive surgery for head and neck cancer can present distinct challenges due its anatomical complexity and effects on function. ENT UK and NICE guidance specify the importance of communicating feeding regime changes in these patients to prevent post-operative morbidities such as aspiration and infection. Following an audit, we piloted a traffic light system displayed behind the patient's bed. This system helps to communicate the patient's oral intake status, nil by mouth, water or diet. A further audit confirmed the traffic light system has improved communication and patients keeping to their feeding regimes.	Following the successful pilot, the traffic light scheme is now fully implemented. The project will be audited further in 2017/18 to ensure the clear communication of feeding regimes continues.  Instructions for oral intake
Intra-operative facial nerve monitoring The facial palsy unit now uses state of the art intra-operative facial nerve monitoring to delineate the course of the facial nerve and identify the nerve and its branches intra-operatively. This has been shown to substantially decrease the risk of iatrogenic facial nerve injuries.	From 2017 onwards, QVH facial palsy unit in collaboration with the specialist skin cancer multidisciplinary team also offers the specific management of skin cancers over the temple, which have a high incidence of damaging the frontal branch of the facial nerve leading to brow and forehead paralysis. This allows for the safe removal of the cancer whilst also preserving function.
Early diagnosis of occult cancers masquerading as facial paralysis In a small proportion of patients with Bell's palsy, the underlying cause is an occult cancer. Using the QVH facial palsy protocol system, these tumours can be diagnosed much earlier, where appropriate by taking a biopsy next to the facial nerve. Once the tumour is removed immediate nerve repairs or transfers are performed to rekindle facial movement. This close working relationship between the by the maxillofacial and facial palsy teams at QVH translates into the best possible care for patients.	Using one of the chewing muscle (masseter) nerves, it has been possible to minimise donor nerve morbidity when redirecting neural stimulation whilst at the same time, significantly increasing probability of success given the rich nerve density of the masseteric nerve (2900 axons/nerve). This innovation, introduced to QVH in 2016, has changed the surgical landscape in facial reanimation and in 2017/18 we plan to use further for patients with acute or early facial nerve damage following tumour resection.
Scar study The QVH scar study will help scientists and doctors work towards improved healing for the millions of people affected each year by scarring. Severely scarred areas require regular surgery to relieve tension across joints as the body grows and changes. To date there is no reliable effective treatment or cure. Researchers carefully process and store scar samples in order to provide a resource to analyse how the scar has formed. The scar tissue is donated by QVH patients undergoing surgical revision or reconstructive surgery and the work is funded by the Blond McIndoe Research Foundation. This work with scar tissue brings us a step closer to the ultimate goal of scar-free healing. By being able to work with human scar tissue we will better understand the process of scar formation. Scientists can use it to look at the role of key molecules and proteins in individual patients, and that will help us to understand the body's own regenerative processes and eventually target the right treatment for patients.	There are no scar tissue biobanks in the UK, and we hope this work in QVH will allow us to work towards the country's first, and help other research groups working on scarring, both nationally and internationally. Work in 2017/18 will include further developing our academic links.

2016/17 achievements	Further work for 2017/18
Vermilion mucosal advancement flap In a technique, first described at QVH, a 'scarless' form of lower lip excision can be used to re-direct the smile vector following Labbe procedure or even to improve oral competence in stroke patients. This process leaves no visible scar which is a significant issue for facial palsy patients.	From 2017 onwards, the QVH facial palsy unit is also exploring other methods of scarless wound healing in the management of facial palsy patients.
Clinical trials of a smart bandage which detects infections Current research linked to the life-changing reconstructive surgery, burns care and rehabilitation services provided at QVH includes clinical trials of a smart bandage which changes colour when it detects infections. The nature of burns wounds means signs and symptoms of infections are common but true infection is rare. Swabs and used dressings from hundreds of patients are being tested in the laboratory to see how sensitive the bandages are to the infections they are designed to detect. The colour-changing bandage will provide an early-warning that infection is developing, allowing swift treatment for patients. It will also prevent unnecessary tests in patients who do not have infection and avoid unnecessary use of antibiotics.	The use of the smart bandage may identify infection earlier and help to reduce complications. QVH will continue to recruit patients to this clinical trial within 2017/18 to ensure an adequate data sample for analysis, to prove whether the smart bandage has the intended benefits.
Antimicrobial stewardship assurance framework A QVH antimicrobial stewardship assurance framework has been developed to ensure that the Trust complies with the main national antimicrobial stewardship recommendations. A daily review (Monday - Friday) of all antimicrobial prescriptions is carried out across QVH by pharmacists, and a weekly antimicrobial stewardship round is undertaken by antimicrobial pharmacist in conjunction with the microbiologist. The World Health Organisation antibiotic awareness week in November 2016 was marked with an awareness campaign around usage and prescribing of antibiotics at QVH.	Progress implementing the improvement plan actions continues to be monitored on a regular basis. Work continues on the antimicrobial CQUIN data collection and this will continue into 2017/18. An app for antimicrobial guidelines is being rolled out across QVH, funded by the League of Friends. This will give prescribers access to QVH antimicrobial guidelines through their mobile devices, and so improve compliance.
Microsurgical laboratory opening In December 2016 QVH formally opened its microsurgical laboratory, funded via a generous donation to the QVH Charity. The microsurgical skills laboratory enables all plastic surgery and maxillofacial surgery trainees to develop and maintain their skills in a safe environment, and also provides an opportunity for microsurgical research. The laboratory follows the MI4 East of England microsurgical training programme. Training is provided by plastic and maxillofacial consultant surgeons, and through self-directed learning.	In the next year there are plans to move and develop the simulation theatre to give greater access to training using the manikin and to make more efficient use of the space.

Clinical effectiveness achievements

2016/17 achievements	Further work for 2017/18
National recognition for breast reconstruction nurse specialists QVH's Macmillan breast reconstruction clinical nurse specialists have had their service recognised nationally and over the last year we have been approached by partner hospitals to help improve and develop their own services. The team have been invited to teach external breast cancer care telephone support services, and continue to be approached to attend events and study days which promote breast reconstruction outside of QVH.	The team will continue to promote their knowledge and expertise over the forthcoming year, to help support external organisations looking for advice and guidance. The service is passionate about improving the care of our breast patients across the region, exchanging ideas which will enhance the service and maintain the channels of communication between the plastic surgery centres.
Femtosecond laser for specialist eye surgery QVH has invested in the latest femtosecond laser technology to improve patient outcomes and experience. The femtosecond laser is used to perform corneal transplants and intracorneal ring placements with a greater degree of accuracy than manual techniques. The procedures are usually performed under local anaesthetic which provides benefits to patients with quicker rehabilitation and also reduces costs associated with inpatient care for commissioners. As the laser is located within an NHS facility, procedures are also able to be performed under general anaesthetic. This makes the procedure accessible to children and people with learning difficulties, in alignment with the Trust's equal opportunity responsibilities.	We have invested in further technology to enable us to perform high-tech state-of-the-art corneal transplantation by making precise cuts in the cornea using a laser rather than a blade. This development will have a number of benefits for our patients including: better clinical outcomes; shorter healing time; fewer complications, ability to perform highly complex cases, and increased patient satisfaction. QVH hopes to become the national centre for using this type of laser in managing corneal diseases in children.
Enhanced recovery after head and neck surgery The QVH enhanced recovery programme for head and neck surgical patients aims to reduce the physical trauma of surgery. It is a collection of strategies in a structured pathway that supports the multidisciplinary team (surgical, anaesthesia, allied health professionals and ward staff) to work together to optimise patient outcomes, including early discharge where appropriate.	An audit is in progress to ensure the effectiveness of the pathway and to review its impact on patient care. We are currently working to adapt the programme into a digital format, compatible with Evolve, the Trust's electronic document management system. The use of this pathway and the benefits for patients will continue to be publicised.

"QVH is now established as the leading centre in the UK for corneal neurotisation, a revolutionary sight-saving procedure."

2016/17 achievements	Further work for 2017/18
Sentinel node biopsy for head and neck QVH commenced head and neck sentinel node biopsy in September 2016, following the recommendation made in NICE clinical guideline NG36: cancer of the upper aerodigestive tract: assessment and management in people aged 16 and over published in February 2016. Two members of the QVH head and neck consultant body were involved in the formulation of these guidelines and are now members of the NICE quality assurance implementation group. To date, we have achieved validation of 70% of our sentinel node biopsy cases. QVH's lead head and neck clinician worked with NICE to publish Setting up a service for sentinel lymph node biopsy in patients with early oral squamous cell cancer to ensure learning can be shared nationally.	We will continue to work towards the 100% validation of cases. Once achieved this service will be rolled out to all head and neck cancer patients with early oral cancer as recommended in the NICE NG36 clinical guideline.
Super-selective neurotisation of mimetic smile muscles World-first: Clinicians at QVH have recently developed a novel surgical procedure using the masseteric nerve to target specific smile muscles and transfer neural energy in a synergistic manner. This is a less invasive and shorter procedure, specifically designed for the augmentation of the weak smile and is showing promise over contemporary procedures such as the Labbe procedure and free functional muscle transfers. We hope that this procedure will revolutionise facial reanimation world-wide.	In 2017/18 the direct neurotisation principle will be extended to patients who suffer from tongue paralysis. These procedures, based on the brachial plexus, have been shown to allow better speech. The QVH facial palsy and hand surgery teams working in partnership will be the first in the UK to provide this revolutionary technique, first described by Terzis in the US.
Corneal neurotisation UK-first: Using the direct neurotisation principle, the sensation of the cornea (eye) can be returned in those with previously absent eye sensation and loss of the blink response. Guided by the Toronto Hospital for Sick Children, QVH is now established as the leading centre in the UK for this revolutionary sight-saving procedure.	Our work in the past year has now established QVH as the sole centre for reinnervating the cornea in the UK and Europe. A clinical trial is now under way in collaboration with the Moorfields Eye Hospital to determine corneal sensory patterns using confocal microscopy alongside a comparison of different technique of the procedures.
Chimeric vascularised nerve grafts Using a technique developed in Japan, QVH now offers multi-component nerve free flaps including skin, fat and/or muscle for the early reanimation of facial paralysis. This is ideal in reanimating the face as well as re-establishing the normal contour and surface anatomy of the face. Vascularised nerve grafts have been recognised as having the highest success rate of nerve regeneration world-wide and are ideal for very complex facial nerve injuries and in those with extensive scarring from surgery or radiation.	From 2017 onwards, the QVH facial palsy and maxillofacial teams, working in partnership with the ENT and neurosurgery departments in Brighton, are offering patients immediate/early facial nerve reconstruction for the best possible outcomes in cancer patients with facial palsy.

Patient experience achievements

2016/17 achievements	Further work for 2017/18
Nipple tattooing for breast care patients QVH continually considers the holistic assessment and treatment of all patients. This is particularly the case for our breast patients who have had life changing treatment. We offer a nurse led nipple tattooing service and there is an increasing demand for this. The service has grown from 130 appointments in 2008/09, to 290 in 2015/16. The frequency of clinics has been increased to ensure we can meet the needs of our patients and manage waiting times; from March 2017 we will be holding two clinics a week, every week.	QVH will undertake a nipple tattoo audit to help identify improvements to the service and care of our patients.
Facial palsy screening tests The facial palsy unit at QVH, now utilises the latest facial screening tool, based on those used in Harvard, for all patients presenting with atypical forms of Bell's palsy. Using contrast-enhanced MRI scans of the brain and skull base for example, the facial palsy unit at QVH has now accumulated the world's largest series of vascular loops abutment of the facial and vestibule-cochlear nerve. Using QVH facial palsy botox management regimes and internet-based training videos, the majority of these patients have found relief without having to resort to extensive brain surgery.	In 2017/18, the facial palsy team at QVH, in partnership with surrounding hospital emergency departments, is in the process of setting up a pilot scheme for the early referral of Bell's palsy cases to a QVH-based 'hot' clinic where patients with these conditions can be properly managed from day one onwards as opposed to the current situation where most Bell's palsy patients' are left without early to intermediate medical follow-up. Eventually, this scheme will be rolled out nationally via an internet-based referral and telemedicine management system.
Community services expanded QVH is an accredited AQP provider of community urology services and in 2016 won the contract for ear, nose and throat (ENT) provision. GPs can refer patients to a consultant-led outpatients service that provides rapid and comprehensive assessment, diagnosis and treatment for non-urgent conditions. Appointments are offers at a number of sites including East Grinstead, Haywards Heath, Crawley and Worthing. The service includes a range of on-site diagnostics with day case surgical interventions where appropriate. Advice is also available for GPs.	In 2017/18 QVH is expanding into another site in Tangmere near Chichester, West Sussex for community ENT. An investment in equipment at this site has also been made to ensure a range of diagnostics can be provided that will enable patients to be seen and treated as soon as possible.
Restore breast reconstruction show and tell events Restore is an information and support group set up by patients and their breast reconstruction nurse specialists at QVH. The team runs very informal show and tell events throughout the year, where women contemplating breast reconstruction can come along, to meet other women who have already been through their reconstruction journey and see the results of their surgery. This provides the ideal forum for our patients to discuss all aspects of breast reconstruction. Our breast reconstruction nurse specialists are also on hand to give advice about what to expect during a stay in hospital and answer any medical questions. All monies raised during these events are used to improve care of breast reconstruction patients in the South East.	The Restore events have been extended over the last year to hospitals in Kent and West Sussex. Other hospitals have shown interest in hosting similar events using our format. These links will be developed in the future.

2016/17 achievements	Further work for 2017/18
Improved patient experience of food We have listened to our patients who have asked for more varied menus. For our evening meals we serve two hot choices or a salad or sandwich. For lunch we offer two hot choices or a sandwich. Our 'chef of the day' makes daily visits to each ward to ensure the quality of food that is being served, and speak to patients who have any specific dietary requirements. Healthier eating options, soft/pureed food items which are easy to chew and swallow, gluten free and vegetarian options continue to be incorporated into the menus. We ensure that patients have ready access to drinks and snacks between meal times, which is important for those with small appetites.	We will continue to monitor satisfaction with food through patient surveys and benchmarking against our peers. The Trust's 2016 inpatient survey showed significant improvement in food choices.

Duty of Candour

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

QVH promotes a culture that encourages candour, openness and honesty at all levels. It is an integral part of our culture of safety, which also supports organisational and personal learning. The board is committed to openness and transparency at all levels across QVH, including being open and honest with patients. We have undertaken a number of initiatives to ensure that we are effective in embedding the Duty of Candour into our systems and processes.

Staff recognising when the Duty of Candour applies, was identified as an area of weakness during recent Compliance in Practice inspections. However, when prompted, staff are able to demonstrate an understanding of the Duty of Candour principle, and how to apply it in everyday practice if something went wrong.

To support staff and embed this knowledge further the Compliance in Practice inspection questions have been revised, and also focus more on the multidisciplinary team treating our patients.

"Our 'chef of the day' makes daily visits to each ward to ensure the quality of food that is being served"

Statements of assurance from the Board of Directors

Review of services

During 2016/17, Queen Victoria Hospital NHS Foundation Trust provided 21 NHS services including burns care, general plastic surgery, head and neck surgery, maxillofacial surgery, corneoplastic surgery and community and rehabilitation services. QVH has reviewed all the data available to it on the quality of care in all of its NHS services. The income generated by the relevant health services reviewed in 2016/17 represents 90% of the total income generated from the provision of relevant health services by QVH for 2016/17.

"Pioneering techniques developed at QVH in the past are now used routinely in the care of patients all over the world. "

Research

Pioneering techniques developed at QVH in the past are now used routinely in the care of patients all over the world. This includes burns reconstructive surgery, cell culture and hypotensive anaesthesia. Our current research programme focusses on developing techniques in wound healing and reconstruction. We are proud to be holders of NIHR RfPB, NIHR i4i, MRC and Wellcome grants and believe this reflects the quality of our research.

We have strengthened our relationships with our key academic partners including the University of Brighton, Brighton and Sussex Medical School and the University of Sussex. We have also established new collaborative work with the University of Oxford and the University of Bath. Wide networks are critical to successful research investment and outputs, especially in the specialised fields of practice we undertake here at QVH. We are grateful for the ongoing support of our local clinical research network for core research infrastructure, and have significantly increased our participation on national portfolio studies.

The total number of participants recruited to research ethics committee approved studies in 2016/17 was 346, with QVH taking part in 32 studies. Our participation in research demonstrates our continued commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Participation helps our clinical staff to stay abreast of the latest treatment possibilities and enables us to deliver improved patient outcomes.

Participation in clinical audits and clinical outcome review programmes

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

During 2016/17, three national clinical audits and three clinical outcome review programmes (previously known as confidential enquiries) covered relevant health services that QVH provides.

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

Participation ✓ Yes ✗ No

% of cases submitted 100% Percentage ND No data - figure unavailable as audit ongoing

Participation in national clinical audits 2016/17

6th National Audit Project of the Royal College of Anaesthetists - Perioperative Anaphylaxis, UK ✓ 100%	Breast and Cosmetic Implant Registry (BCIR) ✓ 100%	Head and Neck Cancer Audit (HANA) (historical data set) ✓ 100%	National Ophthalmology Audit ✓ ND
NHS (National Clinical Analysis and Specialised Applications Team) - 7 Day Services Survey ✓ 100%	National Audit of Breast Cancer in Older People (NABCOP) ✓ 100%	Female Genital Mutilation Enhanced Dataset ✓ 100%	National Audit of Dementia ✓ ND

Participation in clinical outcome review programmes 2016/17

Child death review database ✓ ND	Cancer in Children, Teens and Young Adults (NCEPOD*) ✓ ND	Chronic Neurodisability (NCEPOD*) ✓ ND	Young People's Mental Health (NCEPOD*) ✓ 100%
Learning disability mortality review programme (LeDeR) ✓ ND	Physical and mental health care of mental health patients in acute hospitals (NCEPOD*) ✓ 100%		

* National Confidential Enquiry into Patient Outcome and Death

Two national clinical audits were reviewed by QVH in 2016/17.

UK National Flap Registry and Breast Implant Registry

QVH contributes to the statutory registration of all reconstruction and cosmetic implants, a system which went live in October 2016. Data collected from the registry will be officially released from 2018, but QVH is currently reviewing the patient reported outcome measures (PROMS) already produced, to help improve our patient outcomes. One of QVH's lead breast care surgeons has been instrumental at a national level in the setup, design and implementation of a national free flap registry.

Seven day services in the NHS

Seven day services ensure that patients admitted as an emergency, receive high quality consistent care, whatever day they enter hospital.

QVH has participated in the bi-annual seven day services assessment which helps to measure our services against the four priority clinical standards for implementation. These are that patients do not wait longer than 14 hours for an initial consultant review; get access to diagnostic tests with a 24 hour turnaround time, 12 hours for urgent requests and one hour for critical patients; get access to specialist, consultant-directed interventions and those with high-dependency care needs receive twice-daily specialist consultant review; and patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds.

We review the findings of each assessment to identify any action needed to ensure that QVH is able to meet these standards for our patients.

Local clinical audit

The reports of 57 completed local clinical audits were reviewed by QVH in 2016/17. This section includes examples of audit projects undertaken across QVH, their findings and actions taken as a result.

Umbilical colonisation audit

Surgical sterility is a basic requirement of safe surgical practice. During free flap reconstruction of the breast from the abdomen, the umbilicus represents a potential source of bacteria, which may pre-dispose the patient to post-operative infection. This audit is aimed to establish whether current surgical prepping practice at the QVH is sufficient to eradicate umbilical commensal bacteria.

Swabs were taken for all free abdominal flap breast reconstructions over a one month period, and compared to identify whether any bacteria was present. This audit found that the Trust's standard of surgical prepping was achieved in 95% of cases.

The Trust's surgical team members continue to rigorously adhere to the principles of aseptic technique and implement those principles for every surgical procedure to reduce the risk of the patient acquiring a surgical site infection.

Trust compliance with NICE dementia guidelines

This audit looked at NICE Quality Standard 01 Dementia: support in health and social care (referred to as QS01) and NICE Clinical Guideline 42 Dementia: supporting people with dementia and their carers in health and social care.

The audit aimed to assess the care that is currently provided to patients with a diagnosis of dementia, and review the Trust's dementia strategy and how it should be taken forward. The sample included patients with a diagnosis of dementia who underwent treatment at QVH between September 2015 and August 2016.

A retrospective case note review was undertaken looking at the NICE guidance and the aims and objectives of QVH's dementia strategy. In addition, a review of Datix incidents and compliance in practice inspections from the same time period was also undertaken to ensure triangulation of information.

Results demonstrated good compliance with the NICE guidance and a commitment by the Trust to improve services for people with dementia. Areas of improvements are mainly related to documentation and staff training.

Xiapex injection for Dupuytren's disease: audit of practice and cost

The aim of this study was to assess the clinical and cost effectiveness of Xiapex injections in comparison to surgical intervention for the treatment of Dupuytren's disease. This is a highly complex disease which typically starts in the palm along the ring finger and little finger, leading to the thickening and shortening of the normal collagen structures of the hand by forming pathological cords. Most of the time Dupuytren's disease results in hand disability.

As an alternative to surgery Dupuytren's is often treated with Xiapex injections, a natural product out of the bacterium clostridium histolyticum. Xiapex uses precise enzymatic action that dissolves collagen when injected into a Dupuytren's cord.

We audited retrospectively five years of elective patients that presented with Dupuytren's disease and were treated with Xiapex injections. Our results compared to literature suggest that Xiapex treatment is effective and has fewer complications. The cost of a Xiapex injection is significantly lower than surgical intervention. From our sample only 4.2% of patients subsequently required surgical intervention.

Burns intervention audit

The burns pharmacist is part of the multidisciplinary team and visits the ward every week day. The pharmacist will undertake a review the medicines prescribed for both inpatient use and for discharge, organise the supply and provide advice within the burns ward. Whilst undertaking the clinical ward service, pharmacists make and recommend changes to ensure that the medication patients are prescribed is optimised. This audit was designed to look at the type and quantity of interventions made over the period of one month on the burns ward. In total there were 64 interventions, with an average of three interventions per day. Approximately half related to ensuring that patients were correctly prescribed their regular medicines on admission. A further audit is planned looking at the interventions in more details to help identify any common themes. This highlights the importance and effectiveness of our pharmacy team as well as confirming their value to the multidisciplinary team.

Therapist led Botox clinics

Therapist led Botox clinics are an effective way of providing chemodenervation treatment to patients for synkinesis (involuntary muscular movements accompanying voluntary muscular movements). Patient reported SAQ (synkinesis assessment questionnaire) scores show that significant improvement occurs in synkinesis following chemodenervation injections which are highly beneficial in the management of synkinesis following facial palsy. Therapists injecting in clinics are achieving highly successful outcomes for this complex patient group. Analysis showed that SAQ scores after receiving Botox injections were significantly better than the scores before the injections.

Lower Limb Rehabilitation Class

The lower limb class is run weekly for patients recovering from any lower limb injury or surgery, and patients are booked to attend for six consecutive weeks. This year's audit was carried out between July 2015 and 2016 and uses the MYMOP (measure yourself medical outcome profile) and LEFS (lower extremity functional scale) outcome measures to assess patient progress within the class, as well as a patient satisfaction survey completed at the end of the six weeks. This year's audit showed 26 patients from the ages of 21 to 80 years were seen in the class, with the most common complaint being a knee problem. Both outcome measures showed positive results, and the patient satisfaction survey results were overwhelmingly positive too.

Outcomes of the enhanced recovery after surgery pathway in microsurgical breast reconstruction

The enhanced recovery after surgery (ERAS) pathway is a tool used to encourage multidisciplinary collaboration in the peri-operative management of surgical patients, including those undergoing microvascular breast surgery. Patients are actively encouraged to be aware of and participate in steps to improve the outcomes from their surgery to help reduce recovery time, surgical morbidities and length of stay in hospital. This audit included all patients undergoing microvascular breast surgery between 1 January 2015 and 31 August 2015.

The ERAS pathway was introduced to our unit on the 1 May 2015, and the outcomes of surgery were compared between patients admitted on the traditional recovery after surgery (TRAS) pathway and those admitted on the ERAS pathway. A total of 138 patients were included in the study: 72 patients were admitted on the TRAS pathway and 66 patients on the ERAS pathway. There was no significant difference in length of stay in the two groups. There was a non-significant reduction in return to theatre and readmission rate in the ERAS group compared to the TRAS group. Results found a significant reduction in the total number of complications (61% in the TRAS group compared to 29% in the ERAS group), as well as a difference in time to catheter removal, time to independent mobilisation, time to laxative prescription and time to removal of the patient-controlled analgesia, all in favour of the ERAS group. There was no difference in time to drain removal.

An audit to determine that the histopathological diagnosis of dentigerous cysts is consistent with the clinico-radiological scenario

This audit was undertaken to determine how many ameloblastomas (or other lesions) have been misdiagnosed as dentigerous cysts in this Trust since 2012, by correlating the radiological and histopathological features. A dentigerous cyst is a specific type of odontogenic cyst and may be defined as a cyst surrounding the crown of an impacted, unerupted tooth.

Clinical information, available imaging and diagnoses were retrieved for histopathological diagnoses of dentigerous cysts between 1 April 2012 and 31 December 2015 from the departmental database.

The results found that there were 139 diagnoses made in 135 patients (four patients had been biopsied twice). The diagnosis of dentigerous cyst was inappropriately entered into the database in 21 patients, but the correct histopathological diagnosis had been issued. In five of the 21 patients the clinical diagnosis on the histopathology request form was a dentigerous cyst despite the cyst being associated with a carious or root-filled tooth, i.e. incorrect terminology had been used on the request form. Re-examination of the histology also revealed misdiagnoses in five patients (four odontogenic keratocysts, one unicystic ameloblastoma). None of the misdiagnosed lesions had recurred at the time of completion of the audit. A full report of the findings of the audit has been published in the International Journal of Surgical Pathology (2017, volume 25, pages 141-147).

The East Grinstead Consent Collaborative nationwide audit of consent for head and neck, orthognathic and maxillofacial trauma surgery

The East Grinstead Consent Collaborative (EGCC) was a collaborative audit project, led by oral and maxillofacial trainees, that ran over a one year period. The project aimed to determine nationwide practices in the documentation of consent, from consent forms only, in all three subspecialties of oral and maxillofacial surgery. The project collected consent data for 6,202 patients from 42 units nationwide with 146 collaborators. Analysis of content of the consent forms has shown significant variability in timing of consent, the risks documented and grade of surgeons obtaining consent. Findings also demonstrated that the procedure-specific consent form improves documentation for consent but there was a lack of documentation in key areas. From these findings, our own practice at QVH has improved.

Patient outcomes following therapy intervention for facial palsy

The effectiveness of our facial therapy was assessed for 100 facial palsy patients on their discharge. Effectiveness was assessed using valid and reliable outcome measures. Patients were treated by specialist facial therapists with massage, stretches, neuromuscular rehabilitation exercises and relaxation techniques having been taught using EMG biofeedback in the clinic. Patients were also able to access DVD recordings of stretching and massage techniques to ensure they were exercising correctly and a 14 minute audio guide for facial relaxation.

Facial grading scores averaged 69% post treatment which exceeded the departmental goal of 60%. Mean improvement on the facial disability index was 28% for physical function (from 52% to 80%) and 21% for psychosocial function (from 56% to 77%). Average improvement on the FACE scale was 27% (pre-treatment average 42% and post treatment average 69%).

The results showed significant improvement following therapy in all three outcome measures used. Patients included in the study had all had their facial palsy longer than six months, ensuring that recovery was down to the therapy intervention given rather than natural recovery.

"Outcome measures showed positive results, and the patient satisfaction survey results were overwhelmingly positive too."

Commissioning for Quality and Innovation

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

A proportion of QVH income in 2016/17 was conditional on achieving number of national and local CQUIN goals. We secured 100% of our national CQUIN targets generating £553,360 of income.

For our local schemes, we achieved 98% our local targets generating £825,771 of income.

The local scheme which we did not achieve related to a sub contract held with Sussex MSK Partnership. The year-end value of this scheme was £12,665. We chose not to pursue this local scheme because the potential quality improvement was not proportionate to the time and other resources needed to deliver the scheme.

The national quality initiatives were:

Introduction of health and wellbeing initiatives
QVH staff with musculoskeletal problems are prioritised by the QVH musculoskeletal physiotherapy service. This is beneficial for staff health and wellbeing as well as reducing sickness absence. Recently access for staff has been made quicker and easier with the introduction of a manager approved self-referral initiative. This removes the requirement for employees to have a GP or occupational health assessment prior to referral, effectively reducing the time taken to access the service. Average waiting time for staff accessing the service in 2016/17 was 7.8 working days.

Healthy food for NHS staff, visitors and patients
Improving our patients' experience of QVH food was a major goal in 2015/16 and continued into 2016/17. As part of this national CQUIN, we have taken forward a number of initiatives to ensure that a choice of healthy food is available to patients. Healthy options are available in all catering outlets including vending machines for staff working out of hours. There are no price promotions or advertising for foods high in fat, sugar and salt within the catering outlets.

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

The national CQUIN measured from October to December each year with trusts required to vaccinate 75% of frontline staff as part of an annual immunisation programme. For the 2016/17 programme, a CCG locally agreed variance to the CQUIN was introduced which allowed QVH to include all staff members who had the vaccination elsewhere or declined. QVH achieved the CQUIN in full, with 84.6% of staff engaged and a 51.5% vaccination rate.

Timely identification and treatment of sepsis in acute inpatient settings

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

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

We are currently working to achieve the Sepsis CQUIN scheme 2016/17 and 2017/18; and a quarterly retrospective case note audit is undertaken to review the care and treatment provided. Going forward, we will seek to integrate electronic recording of observations, with automated triggering to outreach and medical staff, into the existing IT infrastructure to enable a more timely and effective review of the patients' pathway. This is anticipated to be introduced in 2018.

Reduction in antibiotic consumption per 1,000 admissions

It is an internationally recognised problem that antibiotics are over prescribed and used unnecessarily for conditions that are best treated differently. QVH has reviewed national guidance and taken a number of steps forward to reduce the unnecessary prescribing of antibiotics across the Trust. We monitor and scrutinise our antibiotic usage on a monthly basis, and report our data externally to Public Health England quarterly. To support this we are delivering training to doctors and nurses to raise awareness of good antibiotic prescribing.

Empiric review of antibiotic prescriptions

When a patient who is staying in hospital is prescribed antibiotics, it is important that they are reviewed regularly to assess if the antibiotic is still necessary, or whether it can be stopped or if it needs to be changed to a different type. This ensures that antibiotics are being used appropriately and provides our patients with the best possible care and treatment. This patient review is monitored on a monthly basis, and reported both internally and externally to Public Health England on a quarterly basis. QVH has rolled out bright orange stickers within inpatient areas which Pharmacists attach to the patient's prescription card, as a reminder to prescribers that a review needs to be undertaken.

"...we have taken forward a number of initiatives to ensure that a choice of healthy food is available to patients."

Local quality initiatives were:

Health and wellbeing mindfulness
To help improve the health and wellbeing of staff at QVH, we developed a mindfulness course and a programme of follow-up sessions throughout the year. Both the course and follow up sessions were evaluated throughout to ensure they made a positive benefit to attendees and the objectives of the programme were met. Psychometric measures taken both at the start and end of the programme found that participants reported a 43% reduction in stress and 60% reduction in anxiety. Analysis of qualitative replies indicated mindfulness was helpful in a number of areas, particularly in work-based situations, including managing stress and working relationships, with 67% of participants feeling that it had been very or extremely helpful.

Improving dementia patients' experience
In 2013, QVH introduced the butterfly scheme for dementia patients which empowers people with dementia and their carers to choose the care they want. Patients with a diagnosis of dementia or memory impairment, assisted by their carer, can choose to use a butterfly symbol to request dementia-specific care.

The care of people with dementia remains a priority for QVH, and through assessment of risk our aim is to provide the best possible support and care for people with dementia, their families, and carers.

A local guideline on management of patients with dementia at first outpatient appointment has been developed which ensures that a 30 minute time slot can be booked to give extra time to help communication and fully understand the patient's needs. A new carers' policy has also been developed to ensure that loved ones and friends are supported when a patient accesses services at the Trust.

Theatres safety culture
This local CQUIN focussed on improving the implementation of the Five Steps to Safer Surgery within the operating theatre environment, with a specific focus on the quality of the debrief process following surgery.

The QVH safety leads and champions are instrumental in driving forward safety improvements within our theatres. Training on human factors has been delivered to our current leads and champions who act role models, and are always on hand to provide advice and support for colleagues. A review of human factors are considered as part of all incident investigations, and findings are discussed at multidisciplinary team meetings attended by surgeons, anaesthetists, operating department practitioners and support staff.

A rolling programme of observational audits have been implemented to help identify areas of poor practice and monitor improvements made.

NexoBrid
QVH gained approval from our local CCGs to conduct a yearlong trial of using NexoBrid as a quality improvement initiative in burns care. NexoBrid is a novel debriding agent that is able to breakdown burned tissue and leave healthy tissue intact without the need for surgery. In phase II and III trials NexoBrid was shown to reduce the need for patients with deep burns to require surgery, reduce blood loss in surgery and improve wound closure times.

By April 2017, more than 30 patients have received NexoBrid treatment with an average healing time of 31 days.

In a group of patients all of whom would previously have required surgery, the use of NexoBrid meant that 68% healed without surgery.

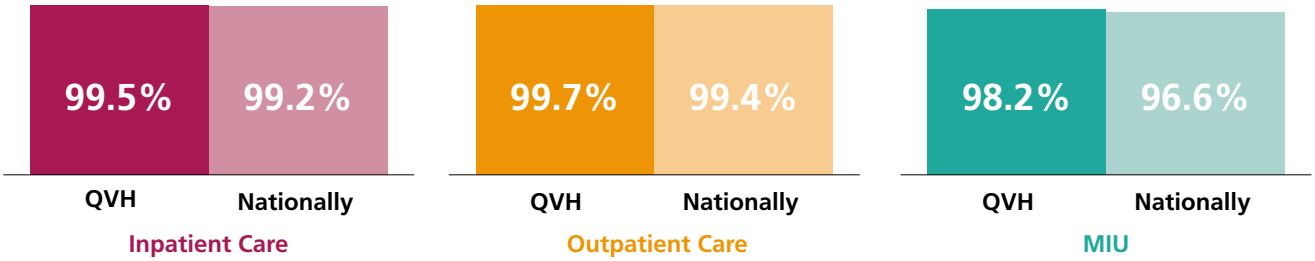
In order to complete the initiative staff had comprehensive training from the manufacturers. Nursing staff have been engaged in identifying suitable patients and collected data on efficacy. The final report is being produced for the CCG and is likely to be published in a peer reviewed journal.

"the butterfly scheme for dementia patients empowers people with dementia and their carers to choose the care they want"

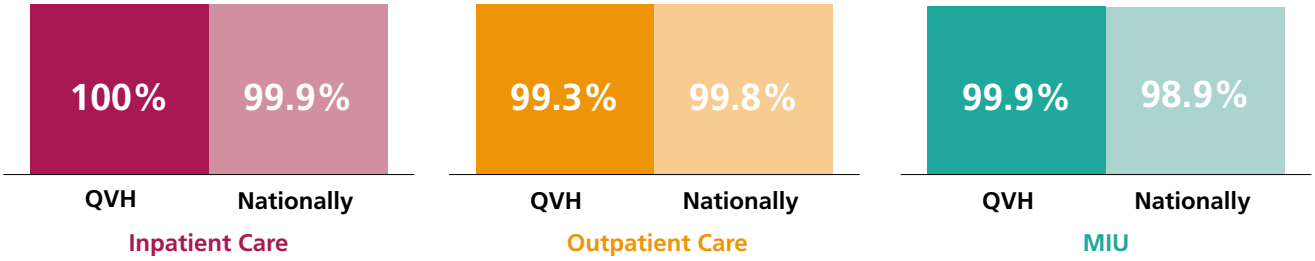
Hospital Episode Statistics

QVH submitted records during 2016/17 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics.

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



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



Source: The figures are aggregates of the QVH entries taken directly from the SUS data quality dashboard provider view, based on the provisional April - November 2016 SUS data at the month 8 inclusion date.

Information governance assessment

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

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

One of the key responsibilities of the information governance group is to oversee the annual information governance toolkit assessment. The toolkit is an online system which allows NHS organisations to assess themselves against relevant policies and standards. The information governance agenda is constantly evolving. During 2016/17, priority was given to cyber security and in particular addressing any threats to our systems, processes and data. Intelligence has been used to create an action plan which includes ensuring all staff and volunteers are formally trained and tested on their understanding of the importance of handling data securely.

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

There were no serious incidents that were classified as a level 2 relating to information governance in 2016/17.

QVH's information governance toolkit overall score for 2016/17 was 75% and graded 'satisfactory'.

Payment by results and clinical coding

In 2016/17 an external coding consultancy carried out a clinical coding audit at QVH. Compliance rates for the clinical coding of diagnoses and treatment were:

- Primary diagnoses 90%
- Secondary diagnoses 95.88%
- Primary procedures 96.81%
- Secondary procedures 98.68%.

The following services were reviewed within the sample: children's and adolescent services; dentistry and orthodontics; ear, nose and throat; head and neck cancer services; oral and maxillofacial surgery; hands; ophthalmology; plastic surgery; sleep disorders; breast surgery; skin cancer services; vascular surgery.

"Significant technical advances this year have included the procurement and development of a data warehouse to improve analytics and data accessibility"

Improving data quality

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

In the last year the data quality improvement group have progressed actions to improve data quality driven by opportunities found in internal and external audits.

Significant technical advances this year have included the procurement and development of a data warehouse to improve analytics and data accessibility, and the delivery of a regular data quality dashboard that highlights areas for improvement.

In 2017/18, QVH will be taking the following actions to improve data quality:

- Continue to work with external parties to improve the depth and insight offered in reports for business intelligence and enhance the value of the data warehouse services to improve timeliness and visibility of data for validation.
- Proactively engage with patient-facing services to improve the quality of collected data through training and understanding of the value of minimum data sets.
- Streamline and standardise forms used to collect data, to help reduce variation which can impact data quality.

Registration with the Care Quality Commission

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

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

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

The CQC has not taken enforcement action against QVH during 2016/17 and QVH has not participated in any special reviews or investigations by the CQC during this reporting period.

"When we inspected QVH, we saw some excellent practice and outstanding care. We saw that staff were incredibly caring and compassionate with patients, and patients praised the care they received." Alan Thorne, CQC Head of Hospital Inspections (South East).

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

QVH received an overall rating of 'good' and was rated 'outstanding' for the caring domain. The full breakdown of ratings for all five domains assessed by the CQC was:

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

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

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

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

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

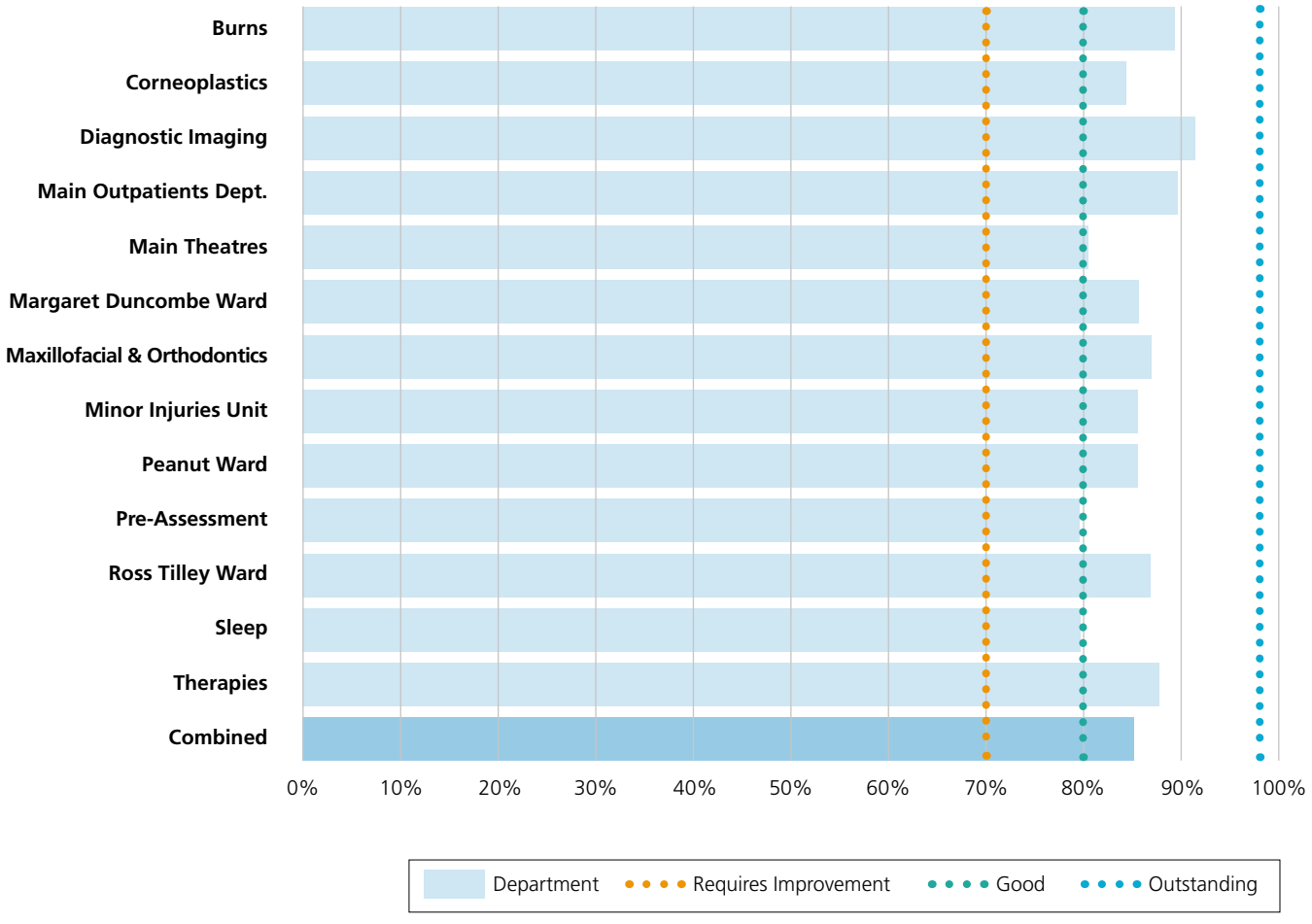
Compliance in Practice inspections

Compliance in Practice is an improvement initiative undertaken across the Trust.

Inspectors are recruited from the QVH staff base and include a variety of clinical and non-clinical stakeholders, as well as members of the board and council of governors.

The structure of the inspections reflects the enquiry lines pursued by the CQC and, as such, assists in enabling the Trust to maintain, and endeavour to improve, its current inspection rating.

2016/17 compliance in practice inspection ratings



National core quality indicators

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

For each statutory indicator, our performance is reported together with the national average. The performance of the best and worst performing trusts nationally is also reported. Each indicator includes a description of current practice at QVH, preceded by the wording 'we believe this data is as described for the following reasons' which we are required to include. QVH has also included additional non-mandated quality indicators to provide further detail on the quality of care provided.

Mortality

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

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

In-hospital surgical mortality

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

Source: QVH information system

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

The Trust has reviewed *Learning, candour and accountability: a review of the way NHS trusts review and investigate the deaths of patients in England* (CQC, December 2016) to ensure that any learning can be disseminated and added to existing internal processes. Evidence for this report was collected via a CQC information request, which QVH participated in, that explored how NHS acute, community healthcare and mental health trusts investigate deaths and learn from their investigations.

Over the coming three years, QVH will participate in the mortality case record review programme. This programme seeks to develop and implement a standardised way of reviewing the case records of adults who have died in NHS acute hospitals to improve understanding and learning across the NHS about problems in care that may have contributed to a patient's death. We will align internal processes to reflect the findings and learning from this programme as required.

Emergency readmission within 28 days of discharge

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

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

Emergency readmissions with 28 days

	Discharges			Readmissions			28 days readmission rate		
	14/15	15/16	16/17	14/15	15/16	16/17	14/15	15/16	16/17
Under 16	2,164	2,238	2,073	48	63	45	2.22	2.82	2.17
16 +	16,174	17,049	16,613	319	347	327	1.97	2.04	1.97
Total	18,338	19,287	18,686	367	410	372	2.00	2.13	1.99

This data has been updated from the 2015/16 Quality Account to reflect a change in reporting methodology.

Source: QVH information system

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

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

National core quality indicators

Infection control – hand hygiene compliance

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

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

Hand hygiene (washing or alcohol gel use)

Target	2013/14	2014/15	2015/16	2016/17
95%	99%	98.4%	99.1%	99.4%

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

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

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

Infection control – clostridium difficile cases

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

QVH has a robust process in place for collating data on C. difficile cases

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

Clostridium difficile rates

	2012/13	2013/14	2014/15	2015/16	2016/17
Trust apportioned cases	0	1	1	1	Not published, expected July 2017
Total bed-days	18,790	18,362	15,143	14,825	
Rate per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	0	5.4	6.8	6.7	
National average rate for acute specialist trusts	10	10.1	14.2	14.3	
Best performing trust	0	0	0	0	
Worse performing trust	25.2	31.5	62.6	66	

Source: Health and Social Care Information Centre data

QVH continues to maintain its low infection rate through surveillance supported by robust policies and procedures linked to evidence-based practice and NICE guidance. Infection rates are routinely monitored through the Trust's infection prevention and control group and quality and governance committee. QVH strives to meet the challenging target of zero cases per annum.

Reporting of patient safety incidents

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

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

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

Patient safety incidents

	2014/15		2015/16		2016/17 part year
	01/04/14 - 30/09/14	**01/10/14 - 31/03/15**	**01/04/15 - 30/09/15**	**01/10/15 - 31/03/16**	**01/04/16 - 30/09/16**
Total reported patient safety incidents	476	470	381	492	412
Incident reporting rate per 1,000 spells	52	52	52	69	57
Incidents causing severe harm or death	1	0	0	01	2
Percentage of incidents causing severe harm or death	0.2%	0%	0%	0.2%	0.5%
Acute specialist trust benchmarks	**01/04/2014 - 30/09/2014** (per 1,000 bed days)	**01/10/2014 - 31/03/2015** (per 1,000 bed days)	**01/04/2015 - 30/09/2015** (per 1,000 bed days)	**01/10/2015 - 31/03/2016** (per 1,000 bed days)	**01/04/2016 - 30/09/2016** (per 1,000 bed days)
Lowest incident reporting rate	17.63	16.33	15.9	16.05	16.34
Highest incident reporting rate	94.84	108.54	117	141.94	150.63
Specialist trust average total (median)	n=745	n=849	n=822	n=725	n=578
Lowest % incidents causing severe harm	0%	0%	0%	0%	0%
Lowest % incidents causing death	0%	0%	0%	0%	0%
Highest % incidents causing severe harm	3.8%	3.9%	0.6%	0.4%	1.0%
Highest % incidents causing death	1.1%	0.9%	0.8%	0.2%	0.3%
Average % of incidents causing severe harm	0.4%	0.3%	0.3%	0.1%	0.3%
Average % of incidents causing death	0.1%	0.1%	0.1%	0.05%	0.1%

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

QVH encourages all healthcare professionals to report incidents as soon as they occur as we believe that this reflects a positive safety culture. Work has been successful during 2016 to reduce incident investigation timeframes and will be ongoing during 2017/18.

This is helping to improve reporting of patient safety incidents to NRLS and NHS England and the identification of key learning aspects for timely dissemination. This is also one of the areas included in our Sign up to Safety pledges.

WHO safe surgery checklist

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

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

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

Use of the WHO Safe Surgery checklist

	2013/14	2014/15	2015/16	2016/17*
Sign in	98%	100%	99.58%	97.39%
Time out	96%	100%	98.05%	97.99%
Sign out	82%	100%	92.88%	94.59%
	Target 100%			

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

Patient safety is paramount at QVH. A whole-team safety briefing with surgical, anaesthetic and nursing staff occurs before the theatre lists begin. This improves communication, teamwork and patient safety in the operating theatre and is embedded in routine practice.

We continually review the results and actions for improvement which have included human factors training during 2016.

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

Venous thromboembolism

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

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

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

VTE assessment rate

	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17
QVH	100%	100%	100%	100%	93.9%	97.5%	91.87%	93.04%	90.96%	91.88%	93.53%
National average	96.1%	96.2%	96%	96%	96%	95.9%	95.5%	95.53%	95.73%	95.51%	95.64%
National average specialist trusts	97.4%	97.3%	97.4%	98%	98.7%	97.7%	97.23%	97.53%	97.53%	97.4%	97.65%
Best performing specialist trust	99.5%	99.1%	99.9%	100%	99.9%	100%	100%	100%	99.97%	99.96%	100%
Worst performing specialist trust	94.6%	93.3%	94.3%	95%	93.9%	95.1%	93.04%	93.04%	90.96%	82.68%	90.67%

Source: QVH information system

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

QVH undertakes the NHS 'safety thermometer' on a monthly basis in inpatient areas. It provides the Trust with a rate of harm-free patient care and includes the assessment of patients for VTE risk on admission and after 24 hours following admission. It also takes into account whether any prescribed prophylaxis medications were administered.

Work will continue into 2017/18 to ensure that QVH maintains its 95% target for VTE assessments within 24 hours of admission. Performance against this target is measured on a monthly basis using the Trust-wide performance dashboards.

Pressure ulcers

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

- QVH has a robust process for collating the incidence of pressure sores
- A route cause analysis is undertaken for all pressure damage grade two and above
- The 'Purpose T' tool has been introduced to replace the existing tool to enhance staff awareness and education around pressure damage and teaching sessions have been set up for all areas
- QVH uses pressure aiding equipment including hybrid mattresses, seat and head pads and pressure relieving gel pads for long surgical cases.

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

Target	2013/14	2014/15	2015/16	2016/17
0	0.5 (total = 8)	0.6 (total = 11)	0.9 (total = 17)	0.5 (total = 10)

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

A pressure ulcer 'deep dive' audit has been undertaken into the care provided at QVH, and each episode of pressure damage has a full root cause analysis undertaken. Further multidisciplinary training and education on the Trust's Purpose T pressure ulcer damage tool will continue, alongside ongoing monitoring of the tool.

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

Same sex accommodation

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

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

Failure to deliver single sex accommodation (occasions)

Target	2013/14	2014/15	2015/16	2016/17
0	0	0	0	0

QVH is committed to providing every patient with same sex accommodation to ensure that we safeguard their privacy and dignity when they are often at their most vulnerable. We have maintained segregated accommodation during 2016/17 through the use of single rooms and the appropriate planning of patient admissions.

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

NHS friends and family test – patients

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

- QVH has a process for collating NHS friends and family test data across all areas of the Trust
- Data on inpatient and outpatient services is collated internally and submitted to the Department of Health on a monthly basis and published by NHS England
- Patient responses are collected from cards, text messages and integrated voice messaging
- Response rates and patient responses for 'extremely likely/likely to recommend' and 'unlikely/extremely unlikely to recommend' are compared with our specialist trust peers
- Results are presented to the board, quality and governance committee and patient experience group on a regular basis.
- The results are published on the QVH website and shared with staff on a monthly basis.

NHS friends and family test scores (from patients)

	Minor injuries unit		Acute inpatients		Outpatients	
	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17
Percentage extremely likely/likely to recommend	94%	95%	99%	99%	94%	94%
Percentage unlikely/extremely unlikely to recommend	3%	2%	0%	0%	2%	2%
Response rate	25%	27%	51%	48%	18%	17%

Source: QVH information system

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

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

We are very proud of our exceptional NHS friends and family test results and will continue to monitor and learn from patient feedback to ensure we sustain the best experience for our patients.

Complaints

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

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

Complaints per 1,000 spells (all attendances)

Target	2013/14	2014/15	2015/16	2016/17
0	0.4	0.4	0.3	0.3

Complaints per 1,000 spells (Inpatients)

Target	2013/14	2014/15	2015/16	2016/17
0	4.7	4.1	2.8	2.6

Source: Continuous internal audit

At QVH we aim at all times to provide local resolution to complaints and take all complaints seriously. We listen carefully, we are open, honest and transparent in our responses, and welcome the opportunity to do all we can to put things right. Our complaint system gives the opportunity for complainants to meet with managers and clinicians to discuss their concerns. We ensure that staff are made aware if concerns are raised about them and we encourage staff to look at ways they can change their practice or behaviours where appropriate.

Many complaints are resolved locally by front line staff who are empowered to resolve the client's concerns/issues to their satisfaction in a timely manner. The Trust actively encourages front line staff to deal with concerns as they arise so that they can be remedied promptly, taking into account the individual circumstances. This timely intervention can prevent an escalation of the complaint.

During 2016/17, two complaints were referred to the Parliamentary Health Service Ombudsman, and are still under review.

NHS friends and family test – staff

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

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

NHS friends and family test scores (from staff)

	2013/14	2014/15	2015/16	2016/17
Percentage extremely likely/ likely to recommend	94%	91%	93%	91%
Average (median) for acute specialist trusts	86%	87%	91%	88%
Highest scoring specialist trust	94%	93%	93%	95%
Lowest scoring specialist trust	67%	73%	80%	76%

Source: www.nhsstaffsurveys.com

Over the next 12 months we will continue to promote the NHS staff survey and encourage staff to participate. Any issues or concerns identified will be reported to the board and a suitable action plan developed and implemented. We will use the feedback from the survey to support staff to improve the services we deliver and will share our findings so that we can learn from our mistakes. Additional questions have been added to the friends and family test based on key findings from the staff survey.

Staff experiencing harassment, bullying or abuse

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

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

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

QVH	
2015	22%
2016	25%
Average (median) for acute specialist trusts	
2015	23%
2016	25%
Best score for acute specialist Trusts	
2015	16%
2016	17%

Source: www.nhsstaffsurveys.com

QVH has a clear policy and process for managing and dealing with concerns (whistleblowing) raised by staff. Over the next 12 months, we will deliver training for all staff on the new policies and will provide managers with further development on how to manage allegations of bullying and harassment. We have commissioned ACAS workshops on this topic and have developed a new management and leadership programme to provide ongoing support for managers.

> "Over the next 12 months we will be focusing on delivering training aimed at supporting personal development, including providing staff with the skills to fully realise their professional potential."

Equal opportunities for career progression

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

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

Percentage of staff reporting equal opportunities for career progression and promotion

	Yes		No		Don't know	
	2015	2016	2015	2016	2015	2016
QVH	61.8%	55.9%	7.5%	9.2%	30.7%	34.8%
Average (median) for all trusts	59.2%	59.3%	11.0%	10.0%	29.8%	30.6%

Source: NHS staff survey

QVH currently delivers a high level of statutory and mandatory training, and compliance levels are reviewed by business units each month. Over the next 12 months we will be focusing on delivering training aimed at supporting personal development, including providing staff with the skills to fully realise their professional potential and take up progression and promotion opportunities. In addition, we will be encouraging recruiting managers to advertise secondment opportunities that give staff the chance to demonstrate that they have the skills required to undertake more senior job roles. QVH will continue to promote apprenticeship opportunities to new and existing staff. It is expected that we will increase the numbers of apprenticeships across the Trust in 2017 as part of our staff progression action plan.

NHS Improvement national priority indicators

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

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

QVH's 2016/17 performance against these indicators was:

			Performance			Quarterly trend		
		National priority indicator	Target	Annual	RAG	Q1	Q2	Q3
Safety	**Infection control**	Clostridium difficile acquisitions	Fewer than 12 cases	2		1	0	1
Experience	**Referral to treatment times**	% incomplete pathways less than 18 weeks RTT	92%	91.6%		92.1%	91.1%	91.8%
	Minor Injuries Unit access	Attendees completing treatments and leaving within 4 hours in minor injuries unit	95%	99.1%		99.1%	99.2%	99.6%
Effectiveness	**Cancer access – initial appointments**	Urgent cancer referral seen within 2 weeks wait	93%	94.2%		90.7%	96.4%	95.9%
	Cancer access – initial treatments	% of cancer patients treated within 62 days of urgent GP referral	85%	81.7%		81.1%	81.2%	82.6%
		% patients treated within 62 days form screening referral (Screening service not offered at QVH, all patients are on a shared pathway with other providers)	90%	54.5%		50%	100%	50%
		% treatment started within 31 days from decision to treat, first treatment	96%	93.3%		91.2%	95.1%	93.4%
		% treatment started within 31 days from decision to treat, subsequent treatment	94%	96.4%		98%	90.1%	95.5%

Source: QVH information system.
Results for quarter 4 are not included as these were not verified within the year 2016/17.

NHS Improvement national priority indicators

Cancer patients treated within 62 days

This year, a trajectory target was agreed with partners in the Sussex and East Surrey Strategic Transformation Plan area for the cancer waiting time target of the first definitive treatment occurring within 62 days of an urgent GP referral for suspected cancer. For the first three quarters of 2016/17, the Trust failed to meet the trajectory target by a small margin. The quarter figures were as follows:

	Q1	Q2	Q3
Trajectory target	81.5%	81.6%	85.3%
Achievement	81.1%	81.2%	82.6%

Data for Q4 is not available at time of publication.

The main issues in not achieving the target were a very small denominator (where one patient can have a several percentage point impact) and late referrals from other trusts. We continue to work closely with referring trusts. This includes regular liaison with off-site management teams to improve processes for joint pathways; discussions with individual trusts when an immediate breach has occurred due to the unavailability of a visiting consultant or any other reason; raising concerns with other trusts and asking them to review systems; and closer liaison with health records managers so that the cancer administration team has full access to all oncology referrals.

18 weeks referral to treatment times

These measures relate to patients who are waiting to be treated. They may have been seen, but are awaiting a first definitive treatment. National and local NHS standards require patients to be admitted for surgery or scheduled (elective) services within 18 weeks of referral by their GP. The quarter figures are as follows:

	Q1	Q2	Q3
Trajectory target	92%	92%	92%
Achievement	92.1%	91.1%	91.8%

Data for Q4 is not available at time of publication.

The Trust has narrowly missed the target for the last two quarters. This is due to late referrals, an increasing number new patients, a focus treating those who have been waiting the longest, plus growth in referrals in specific areas such as Mohs surgery for skin cancer. Plans developed improve these come into place during the first quarter of 2017/18.

In response to the limited assurance opinion from last year's quality report, the Trust prioritised the appointment of a patient access and performance manager to lead a review and redesign of 18-week referral to treatment and 62-day cancer waits. However, this post has proved difficult to recruit to and so has been and at the time of publication remains covered by an interim.

Work is ongoing to review and redesign the cancer patient tracking list, refresh systems and processes to track and validate patients, and train staff.

The separate issue of data quality at our spoke sites presents a different challenge to QVH. Work is underway to improve the quality of all externally supplied data.

"We continue to work closely with referring trusts. This includes regular liaison with off-site management teams to improve processes for joint pathways."

National priority indicators

Operations cancelled by the hospital for non-clinical reasons

QVH treats over 12,000 surgical cases each year and makes every effort to minimise cancelled operations, as shown in the figures below. However, cancellations are unavoidable on occasion, for example when there are more urgent cases that require a theatre. To minimise cancellations, all patients at risk of cancellation are now escalated to the daily business manager. This ensures that all options are considered and cancellations only occur when all other routes have been explored.

	How data is collected	Target	2014/15	2015/16	2016/17
Cancer - 62 day wait from referral to first definitive treatment	Data collected monthly and reported quarterly; performance includes shared care with other providers	85%	87.0%	82.3%	81.7%
18 weeks - incomplete pathways	Data collected from monthly snapshots	92%			91.6%
Minor Injuries Unit - patients leaving without being seen	Data collected from PAS in the minor injuries unit	5%	1.9%	2.4%	1.7%
Operations cancelled on the day of surgery for non-clinical reasons and not rebooked within 28 days	Data collected from PAS and theatre systems	0	3	4	3
Urgent operations cancelled for non-clinical reasons for a second or subsequent time	Data collected from PAS and theatre systems	0	3	3	0

"To minimise cancellations, all patients at risk of cancellation are now escalated to the daily business manager."

Clinical effectiveness indicators

In 2016/17 QVH's clinical specialities continued to be amongst the most experienced and effective in the world.

Head and neck
Survival after 30 days

119 Major cases

99% QVH success rate
98.3% National benchmark

Orthodontics
Improvement in tooth position

13,662 Orthodontic procedures

98% QVH success rate
70% National benchmark

Breasts
Treatment following cancer

255 Immediate breast reconstruction using free tissue transfer

100% QVH success rate
98% National success rate

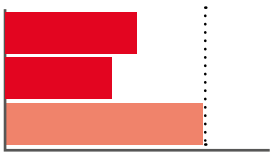
Eyes
Achieved better than 6/12 vision

1,424

100% QVH success rate
96% National benchmark

Burns
Average burn wound healing time

1,110 Adult
607 Paediatric



17 days adults
11 days paediatric
‹ 21 days established benchmark

Skin cancer
Melanomas completely removed

142 Melanomas removed

94.4% QVH complete excision rate
75% NICE national benchmark

Hands
Improvement in function after surgery

1,750 Procedures

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

Anaesthetics

The anaesthetic department at QVH includes 19 consultant anaesthetists, two associate specialists and nine senior anaesthetic trainees with responsibilities to patients before, during, and after surgery. Most of an anaesthetist's time is spent in operating theatres. Anaesthetic doctors work closely with other clinical staff to care for surgical patients throughout the hospital.

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

In 2016/17 QVH performed 1200 upper limb regional anaesthetic blocks for upper limb surgery. In 76% of all upper limb surgery cases, an upper limb regional anaesthetic block was the sole anaesthetic used.

In March 2017, QVH took part in the national Royal College of Anaesthetists-led SNAP2 (EpiCCS) research project. The aim of the project is to look into the epidemiology of critical care, focusing on critical care bed provision and availability, admission criteria for surgical patients and patient outcomes. We recruited over 40 patients in the week-long study period, with 100% of patients fully followed up. Approximately 60 clinicians also filled in questionnaires regarding decision-making around critical care admission and patient risk. As part of a national project, this data should help demonstrate the impact of critical care on patient outcomes and help improve clinical decision-making around post-operative levels of care.

QVH's anaesthetic department are actively engaged in the 6th National Audit Project of the Royal College of Anaesthetists - Perioperative Anaphylaxis in the UK. Findings will be reviewed to ensure any learning points can be used to benefit patient care.

Facial palsy

QVH has the UK's first and largest expert facial palsy service, treating patients with facial palsy and paralysis from across the country. QVH clinicians have also founded the charity Facial Palsy UK which supports people living with facial palsy and their families.

Across the UK the services provided for patients with facial palsy vary, with many patients receiving little or no treatment. Services tend to be fragmented and frequently do not offer a combination of therapy and surgical treatment options in one location. As facial palsy causes physical, functional, social and psychological disability a comprehensive multidisciplinary approach is required to address these complex issues.

The service at QVH was set up in 2007 with the main objective of establishing the first comprehensive UK multidisciplinary facial palsy team. Patients can be seen on the same day, in a single location, by a consultant plastic surgeon, extended scope practitioner physiotherapist/ speech and language therapist, consultant ophthalmologist and consultant psychotherapist. This ensures that each of our patients receive high quality holistic care from our multidisciplinary team.

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

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

Breast surgery

QVH is the major regional centre for complex, microvascular breast reconstruction either at the same time as a mastectomy for breast cancer (immediate) or after all treatment has been completed (delayed). We are increasingly being asked to carry out reconstructions after removing both breasts on the same day in ladies who have a genetic predisposition for breast cancer (e.g. BRCA gene). This is likely to further increase due to high profile media attention and improved genetic screening techniques. Our integrated team of consultants and specialist breast reconstruction nurses provide a wide range of reconstructive options and flexibility and also undertake reconstructive surgery to correct breast asymmetry, breast reduction and, if funding can be obtained, congenital breast shape deformity. We run regular breast reconstruction multidisciplinary meetings with one referring hospital and plan to extend this to others. In addition, we also discuss all mortality and morbidity cases in our breast team meetings once a month to determine if we can learn and improve our breast team service.

Breast reconstruction after mastectomy using free tissue transfer – flap survival

Clinical techniques for breast reconstruction have changed significantly over the last few years and QVH is at the forefront of this. At QVH we expect to continue to see increases in this complex procedure.

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 high patient satisfaction and longevity. It is important we not only monitor our success in terms of clinical outcome but also how the woman feels throughout her reconstructive journey. This is called a patient reported outcome (PROM). If the abdomen is insufficient then tissue can be utilised from the inner thigh or the bottom as a free flap for breast reconstruction.

The numbers of immediate breast reconstruction (at time of mastectomy) surgery patients has increased from 21% in 2013 – 2014, to 48% in 2015/2016. In the last year 255 free flaps were performed with a 0% failure rate. We are predicting that the number of immediate reconstructions will rise over the next year and are looking at ways to ensure the patient trajectory is smooth and within the cancer target dates.

Breast reconstruction after mastectomy using free tissue transfer - flap survival

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

BAPRAS: British Association of Plastic Reconstructive and aesthetic surgeons

the enhanced recovery after surgery (ERAS) pathway and use audit findings to improve and refine this tool to benefit patients. The team hopes to publish its findings in a leading journal on plastic surgery and reconstruction.

In addition, the service is piloting two initiatives going into 2016/17: vascular mapping of vessels for free flaps using magnetic resonance angiography (MRA) and a photo-based post-operative technique which assesses breast volume before and after breast and nipple reconstruction. The service is also starting to carry out breast reconstructions with multiple flaps and combining fat grafting with free flap surgery.

"Clinical techniques for breast reconstruction have changed significantly over the last few years and QVH is at the forefront of this."

Hand surgery

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

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

Over the last six months the hospital has commenced a new upper limb outpatient service, in collaboration with the Sussex Musculoskeletal Partnership, aimed at ensuring that patients are managed within the community where possible and that secondary care is only utilised when appropriate in that individual patients care plan.

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

	2013	2014	2015	2016*	2017 Jan - Mar
Total elective hand procedures	1,422	1,893	1,881	1,750	281
Total trauma cases	2,384	3,084	2,972	3,042	448
Total new outpatient appointments	4,380	5,897	5,780	5,444	840

*Data has been updated from 2015/16 quality report to reflect full years figures

"An increase of 18 or more indicates a significant clinical improvement in the ability to use the hand. At QVH we achieve above this..."

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

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

QuickDASH elective scores before and after treatment

	Initial	Discharge	Difference
Conservative	34.11	11.97	22.14
Major Elective	41.77	12.94	28.83
Lesser Elective	28.16	10.57	17.59
Trapeziectomy	45.12	22.93	22.19
Dupuytrens	19.74	4.5	15.24
Bone	41.4	6.28	35.12
Tendon	42.27	13.77	28.5
Major Trauma	43.95	5.9	38.05
Lesser Trauma	38.15	6	32.15

*data collected January - December 2016

	2014			2015			2016		
	Initial	After	Difference	Before	After	Difference	Initial	After	Difference
Trapezietomy	44.25	12.32	31.93	50.18	19.57	30.61	45.12	22.93	22.19
Dupytrens	20.71	4.78	15.93	20.6	5.5	15.1	19.74	4.5	15.24
Major Elective	44.64	16.94	27.7	35.49	15.37	20.12	41.77	12.94	28.83

Nationally the hand surgery department is involved in research projects including Dupuytren's contracture tissue research and new fixation techniques in fracture management.

On a regional level the department runs a bi-annual burns and trauma training course for medical, nursing and paramedic staff working in these areas as well as providing hand surgery teaching to the pan-Thames plastic surgery training programme.

Within QVH, the department runs a weekly teaching programme for its trainees.

Burns service

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

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

In 2016, the QVH burns service accepted:

- 1,110 adult (over16 years of age) new referrals which was a 1% reduction in referrals,
  - » of which 115 needed inpatient care
  - » with 27 requiring intensive care in QVH's critical care unit.
- 607 paediatric (under 16 years of age) new referrals
  - » of which 30 required inpatient care.

QVH's paediatric ward provides inpatient and day case paediatric services. Children who require critical care are referred to paediatric burns services within the London and South East England burn network (LSEBN) that have the appropriate facilities.

In 2016, three adult burns patients who had sustained major burn injuries died. This equates to an adult burns inpatient mortality rate of 0.1%. There were no paediatric deaths. All patient deaths are discussed at weekly governance meetings so that any learning points can be identified. If further review is required, the patient's case is discussed at a joint hospital governance meeting. All burns mortality cases are also peer reviewed at the annual LSEBN audit meeting with any outlier cases taken to the national burns mortality meeting. None of the three deaths at QVH in 2016 were considered to be outliers. Sadly, all the patients had sustained injuries which, given their age and/or co-existing medical conditions, it was not possible to survive.

Key burns performance indicators are recorded and analysed through QVH's active participation in the international burns injury database (iBID) programme. This compares QVH's performance with that of all other English burns services in relation to set quality indicators. Overall in 2016, QVH achieved better than the national average for the six valid dashboard indicators for both adult and paediatric burns care.

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

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

Average time for burn wounds to heal

Target	2014	2015	2016
Paediatric (under 16 years) wound healing within 21 days	10 days	11 days	11 days
Adults over 65 years wound healing within 21 days	15 days	17 days	17 days
Adults over 65 years wound healing within 31 days	24 days	24 days	28 days

Length of stay

	2014	2015	2016
Paediatric (under 16 years)	2 days	2 days	2 days
Adults under 65 years	6 days	7 days	8 days
Adults over 65 years	5 days	14 days	14 days

Length of stay / percentage burn

Paediatric (under 16 years)	1.25
Adults under 65 years	1.58
Adults over 65 years	1.66

Skin cancer care and surgery

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

Complete excision rates in basal cell carcinoma

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

Basal cell carcinoma is the most common cancer in Europe, Australia and the USA. Management usually involves surgical excision, photodynamic therapy, curettage, immuno-modulators, or a combination. Surgical excision is highly effective with a recurrence rate of just 2%. Complete surgical excision is important to reduce recurrence rates. However, this may not be possible because of the size or position of the tumour or because the incomplete excision will only be evident with histological examination of the excised tissue.

In 2016/17, 1,537 basal cell carcinomas were removed at QVH.

Complete excision rates in malignant melanoma

Target	2013/14	2014/15	2015/16	2016/17
100% 75% NICE guidance	96.5%	96.1%	98.4%	94.4%

Melanomas are excised with margins of healthy tissue around them, depending on the type, size and spread of tumour. These margins are set by national and local guidelines and each case is discussed by the multidisciplinary team. Total excision may not be possible because of the health of the patient or the size, position or spread of the tumour, and the team may recommend incomplete excision. In 2016/17, 142 melanomas were removed at QVH.

"Surgical excision is highly effective with a recurrence rate of just 2%. Complete surgical excision is important to reduce recurrence rates"

Corneoplastic and oculoplastic surgery

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

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

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

Cataract patients with significant astigmatism now receive a specialist toric intraocular lens to correct this; Queen Victoria Hospital now has two new cataract surgery suites with cutting edge implantation technology to improve placement accuracy.

Outcome of femtosecond laser assisted intracorneal ring segment implantation in QVH

A total of 103 patients with keratoconus were included in this study, having undergone femtosecond laser assisted intracorneal ring segment implantation. Each patient was reviewed during outpatient clinic appointments for a minimum period of 12 months to check the stability of their vision.

Keratoconus is a non-inflammatory eye condition in which the normally round dome-shaped clear window of the eye (cornea) progressively thins causing a cone-like bulge to develop. This distorted shape impairs vision and by implanting a ring segment into the affected eye, we are able to improve the shape of the cornea to make it more rounded and regular, which helps to improve the patient's vision.

Following implantation:

The uncorrected vision acuity (without vision aids such as glasses or contact lens) in 83 out of 103 patients (80.58%) improved by enabling them to accurately read two lines or more* on the alphabetic test chart.

For best corrected visual acuity (with vision aids such as glasses or contact lens) in 78 out of 103 patients (75.72%) improved by enabling them to accurately read two lines or more (as recommended by NICE guidance) on the alphabetic test chart.

Results found that cornea shape and cornea astigmatism had also improved.

This surgical procedure also led to no complications during surgery and few, but manageable complications, including: infection (two patients), ring erosion (one patient), in-growth of new blood vessels (one patient), and increased amount of glare from the ring (one patient). No complications were found to result in a permanent loss of visual acuity.

The results found were comparable to those in published literature.

"...a high-profile and technologically advanced specialist centre for complex corneal problems and oculoplastics."

Head and neck

QVH is the specialist centre for major cancer and reconstructive surgery of the head and neck. Our head and neck services are recognised, both regionally and nationally, for the specialist expertise offered by our large consultant body which continues to grow, now with six oromaxillofacial surgeons and three ear, nose and throat surgeons. QVH is recognised by the Royal College of Surgeons as a centre for training interface fellows in advanced head and neck oncology surgery.

Total number of major head and neck cancer procedures

2013	2014	2015	2016
65	106	126	119

In summary 2016:

- Number of major cases - 119
- 30 day survival - 99%
- Flap success rate - 96%

The total number of major head and neck patients treated in 2016 was 119, with a 30 day survival rate of 99%. This compares with a national benchmark of 98.3% for 2014.

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

The QVH enhanced recovery approach for patients undergoing major head and neck cancer surgery was developed by a multidisciplinary team and began in January 2016. It ensures we involve our patients in the care given by the multidisciplinary team and aims to optimise outcomes and reduce lengths of stay. The service is currently auditing one year's worth of data. We are also in the process of converting the enhanced recovery programme into an electronic format in preparation of the full rollout of the Evolve system (digital notes).

QVH commenced head and neck sentinel node biopsy in September 2016, for early oral cancer requiring surgical management, supported by NICE clinical guideline NG36 published in February 2016. By April 2017, we have achieved 70% validation of our sentinel node biopsy cases.

In order to deliver complete head and neck care, including palliative treatments to enhance quality of life, we are well advanced in developing our patient pathways and staff training to enable us to commence electrochemotherapy (ECT) treatment to skin nodules of the head and neck. Currently, patients from Kent, Surrey and Sussex can only access this care in central London and we aim to bring it closer to the patient's home. We are aiming to roll this service out in May 2017. A major provider of ECT, South Tees Hospitals NHS Foundation Trust, has kindly agreed to be our mentor unit.

We also use audit to enhance best practice regarding our major head and neck surgery consent documentation. The consent process is complex and involved to ensure that major risks and benefits are both discussed in detail and also fully documented for the benefit of patients and the clinicians caring for them. QVH drove a major national audit which found that significant numbers of other head and neck units could benefit from the introduction of a similar consent process and form. This nationwide development is supported by the British Association of Maxillofacial Surgeons. This consent project has now been extended to include trauma and orthognathics. Results are due early 2017/18 with the publication of all three sub-sites (head and neck, trauma and orthognathics).

> "Our head and neck services are recognised, both regionally and nationally."

Maxillofacial service - orthognathic treatment

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

Patient satisfaction with orthognathic treatment

	2013/14	2014/15	2015/16	2016/17
How do you rate the orthognathic service and care?	83% excellent 17% good	88% excellent 12% good	95% excellent 5% good	92% excellent 8% good
How do you rate the quality of surgical care?	N/A	91% excellent 8% good 1% average	94% excellent 6% good	90% excellent 10% good
How satisfied are you with facial appearance?	71% very satisfied 28% satisfied 1% neither satisfied nor dissatisfied	68% very satisfied 29% satisfied 3% neither satisfied nor dissatisfied	84% very satisfied 16% satisfied	71% very satisfied 29% satisfied
How satisfied are you with dental appearance?	72% very satisfied 27% satisfied 1% neither satisfied nor dissatisfied	80% very satisfied 20% satisfied	84% very satisfied 16% satisfied	76% very satisfied 22% satisfied Very dissatisfied 2%*

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

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

"Our maxillofacial consultant surgeons have a number of interests in the sub-specialisms of their services including orthognathic surgery, trauma, head and neck cancer, salivary glands and surgical dermatology."

Orthodontics

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

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

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

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

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

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

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

In 2016, 98% of our patients were assessed as 'greatly improved' or 'improved'. This is reflected in the table below:

Percentage of patients achieving an outcome in the improved or greatly improved category

National Gold Standard: 70% in this category

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

*Data is produced one year in arrears

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

In addition to PAR ratings, patients are asked about their satisfaction with treatment. Every patient who completes orthodontic treatment fills out a confidential questionnaire on our outcomes kiosk.

In 2016, 306 patients completed the satisfaction questionnaire. The significant majority (87%) were completely satisfied with the result of their treatment and the remaining 12% were fairly satisfied, and less than 1% a little satisfied. No patient was disappointed.

Furthermore, 99% were happy that their teeth were as straight as they would have hoped.

In addition, 94% of patients were happy with the appearance of their teeth after treatment; 72% reported improved self-confidence; 72% reported an improved ability to keep teeth clean; 56% reported improved ability to chew; and 27% reported improved speech.

A total of 96% of patients felt that they were given sufficient information regarding their proposed treatment; 99% of patients said that they were glad they undertook their course of treatment; and 96% would recommend a similar course of treatment to a friend.

Mandibular advancement splint

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

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

This year saw the third cycle of the patient satisfaction audit. The audit also aims to identify those patients who are most likely to benefit from a mandibular advancement split by investigating the clinical parameters that indicate the highest probability of a positive response.

Our 'on the day digital kiosk' allows patients to capture their treatment feedback as they leave the unit and this has received positive comment.

Overall, the orthodontic sleep service found an 82% resolution in apnoeic symptoms, which is in line with the published literature, as well as patients continuing to have improved wellbeing.

Maxillofacial Prosthetics Service

QVH is Europe's largest maxillofacial prosthetic rehabilitation centre, offering all aspects of care, including facial and body prosthetics, cranial implants, indwelling ocular prosthetics, rehabilitation after head and neck cancer or plastic surgery, surgical guides for jaw alignment surgery. This team were mentioned as outstanding in the last CQC report.

This service at QVH is one of only three accredited maxillofacial prosthetics training institutions, and as such has government funded training posts, under the modernising scientific careers: scientist training programme.

As one of the largest prosthetic rehabilitation centres we offer patients the full range of maxillofacial device treatments and are at the forefront of several evidenced based research projects. One such study just gained favourable ethical and health research authority approval: nationwide artificial eye study, which aims to collect and collate nationwide data on artificial eye patients via a questionnaire. Data was collected on patient cleaning regime, insertion/removal timescales and presence of any deposit/discharge for ocular prostheses, overall experience of prosthetic treatment and quality of life after eye loss. This data will enable investigation into the timescales of adapting to monocular vision and add to the current evidence base available in the published literature. The goal is to produce a simple and readily available information leaflet available in clinics and online. This study hopes to improve patient's artificial eye tolerance and reduce deposit build up, reduce symptoms of discharge, ultimately improving the patient experience. Such evidence based research will inform and prepare patients experiencing eye loss in the future and be useful in NHS clinics, GP surgeries and affiliated organisations.

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

"QVH is Europe's largest maxillofacial prosthetic rehabilitation centre, mentioned as outstanding in the last CQC report."

Sleep disorder centre

The sleep disorder clinic was established in 1992 and provides a comprehensive service in all aspects of sleep medicine for adults from the South East of England. It employs 30 staff, including five consultant physicians and 12 technicians, supported by administrative staff and secretaries. Disturbances of breathing during sleep constitute the largest proportion of the referrals.

The centre is one of only a few in the UK with onsite facilities for a full range of treatments for sleep disordered breathing, including continuous positive airway pressure (CPAP), non-invasive ventilation (NIV), orthodontic services for mandibular advancement devices, and surgery including bi-maxillary osteotomy. The treatment of patients with insomnia is undertaken by a team of five clinical psychologists and psychotherapists using cognitive behavioural therapy (CBT).

Patients can be triaged to either inpatient respiratory polysomnography or outpatient oximetry to diagnose sleep disordered breathing on the strength of their STOPBang questionnaire with scores audited carefully in the early part of 2016. It was shown that the Epworth Sleepiness Score does not contribute to overall patient management and STOPBang score is now used exclusively to determine the type of pathway that the patient will enter. The pickup rate for obstructive sleep apnoea and sleep disordered breathing using this system is high and enables patients to be treated in a timely manner.

Patients are now seen in the morning immediately after overnight respiratory polysomnography so diagnosis and treatment can be planned before they leave the centre. Protocols and pathways have been developed to triage patients, including capillary blood gas analysis. Working in conjunction with the blood gases and a body mass index, patients are now triaged either CPAP or to non-invasive ventilation. This is been very successful and has enabled us to be specific in the type of treatment the patients receive with a high degree of success when outcome is measured.

From April 2017 a satellite clinic will be held in Bognor Regis, and it is hoped that a further clinic will be set up in North Kent.

GP education on diagnosing sleep disorders has continued which enables them to be more confident in what and where to refer.

Diagnostic imaging

The diagnostic imaging department provides general radiography, fluoroscopy, ultrasound and cone beam computed tomography services on site. We also offer an on-site diagnostic and therapeutic sialography service. MRI is delivered on the QVH site, two to four days per week in partnership with a third party provider.

QVH patients referred for CT scans are offered appointments in neighbouring NHS trusts or private providers.

Our diagnostic services provide inpatient, outpatient and minor injuries unit access at QVH and direct access for our local GP community.

The imaging department is an AQP provider for ultrasound services for the Crawley and Mid Sussex and Horsham CCGs.

In November 2015, we partnered with Sussex Community NHS Foundation Trust to provide a general radiography reporting service, radiology management and clinical support for the diagnostic services in the High Weald, Lewes and Havens area.

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

Formal internal performance measurement against report turnaround times began in 2014. Although there is no agreed national benchmark for this, at QVH we expect to maintain a target of at least 80% of all CT, MRI, ultrasound and plain film to be reported within 48 hours.

Monthly returns identify waiting time breaches (waits greater than six weeks where the clock has not been stopped for any reason). The increase we have seen this year is the result of increased referrals, which is stretching our capacity. This continues to be monitored and plans are being put in place to address this.

	Measurement	2014/15	2015/16	2016/17
Report turnaround time	Percentage of CT, MRI, ultrasound and plain film reported within 48 hours	52%	85%	Routinely over 90%
Diagnostic waiting times	Waiting times for routine ultrasound access			2-3 weeks
Diagnostic waiting time performance	Percentage of patients referred for CT, MRI or non-obstetric ultrasound seen within six weeks of referral	99.56%	99.60%	Over 90%

Therapies

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

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

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

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

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

We also use a range of measures, including the NHS friends and family test and service specific surveys to monitor patient satisfaction.

	Target	2013	2014	2015/16	2016/17
Effective (clinical outcomes)					
PSFS change (MSK)	≥ 3	3.99	4.17	4.2	4.24
Quick DASH change- Conservative (Hands)	>18	N/A	19.29	15.16	20.4
Quick DASH change – Surgery elective (Hands)	>18	N/A	22.48	19.18	18.33
Quick DASH change - Surgery trauma (Hands)	>18	N/A	38.97	31.54	33.5
POSAS (Burns)	>5%	N/A	N/A	N/A	7.13%
FGS (Facial palsy)	≥60%	N/A	N/A	N/A	69%
Effective (NP:FU)					
NP:FU ratio (Physio)	≤ 5	4.2	4.6	4.1	3.47
NP:FU ratio (OT)	≤ 5	3.9	4.9	4.5	3.71
NP:FU ratio (SALT)	≤ 5	4	4.6	3.2	3.09
NP:FU ratio (Dietetics)	≤ 5	3	3.7	4.2	4.08
Average NP:FU ratio	≤ 5	3.8	4.45	4	3.58
Discharge reports sent within 7 working days (MSK)	>90%	N/A	N/A	N/A	95%
Shared Decision Making information issued to patients with Knee and Hip OA	>80%	N/A	N/A	N/A	90%
Patient experience					
Patient satisfaction - MSK (%)	>90%	98%	98%	100%	99%
Patient Satisfaction – Rehab (%)	>90%	N/A	N/A	N/A	100%
Patient Satisfaction – Facial Palsy (%)	>90%	N/A	N/A	N/A	95%
Burns standard - FAB review within 72hrs (%)	>90%	N/A	N/A	100%	100%

Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2016 to 23 May 2017
  - papers relating to quality reported to the board over the period April 2016 to 23 May 2017
  - feedback from commissioners dated 15/05/2017
  - feedback from governors dated 12/05/2017
  - feedback from local Healthwatch organisations. Healthwatch West Sussex chose not to comment on this quality account but provide feedback to the Trust through a variety of channels.
  - West Sussex Health and Adult Social Care Overview and Scrutiny Committee chose not to comment on this quality account as they had not been involved in any significant work with QVH in 2016/17.
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 20/04/2017;
  - the latest national patient survey 04/05/2017;
  - the latest national staff survey 07/03/2017;
  - the head of internal audit's annual opinion of the Trust's control environment dated 25/04/2017
  - CQC inspection report dated 26/04/2016
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board,

Chair
23 May 2017

Chief Executive
23 May 2017

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

Horsham and Mid-Sussex CCG welcome the opportunity to comment on the draft quality account 2016/17 and quality of services provided by Queen Victoria Hospital NHS Foundation Trust.

Over the past year, together with other strategic partners, Horsham and Mid-Sussex CCG have worked with the executive team to support the delivery of quality and patient safety improvement. We would like to note the Trust's continual focus on embedding a culture of transparency in encouraging staff to report safety incidences. The Trust has identified three key areas of focus where improvements are a priority for 2017/18, of which the CCG is in agreement, and the quality team welcomes the opportunity to work with the Trust and support the improvements, as outlined within the report especially building on patient safety in the theatres, and are pleased that a priority for 2017/18 is on increased theatre productivity.

The CCG thanks the Trust for the opportunity to comment on the document and looks forward to maintaining and strengthening the relationships with the Trust in the future.

Statement from Healthwatch West Sussex

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

Statement from QVH Council of Governors

Governors welcome the Statement on quality highlighting the areas where the Queen Victoria Hospital NHS Foundation Trust continues to develop innovative and collaborative improvements and solutions in the fields of reconstructive surgery, burns care and rehabilitation. Such activities are wholly in keeping with the great traditions of the hospital and its renowned pioneering plastic surgery development. Smart bandages, research into improved healing with our scar storage work, the opening of our microsurgical skills laboratory and the work on 'smart specs' for facial palsy sufferers are really exciting and important developments for healthcare in the UK.

Governors are interested in the additional focus on the psychosocial aspects of burns healing and surgery and recognise the importance of providing appropriate support to patients who have mental health or other non-physical conditions.

We are pleased to see the Trust is focused on dementia aspects in respect of its innovations and quality account priorities. Improved signage, work on floor surfaces and allowing enough time with appointments to support dementia sufferers are really important initiatives for patients and visitors. Governors expect that all future account priorities will have consideration given as to whether there are dementia or other psychosocial aspects that should be taken into account when thinking about impact on patients and visitors.

The governors at the QVH engage with the Trust and its staff and patients in a number of different ways, this level of engagement was praised in last year's CQC report and this allows us the opportunity to monitor the quality account priorities closely. We support increased theatre productivity to improve patient experience and safety, it is also an essential area of review from a financial perspective. We also support improvements to waiting areas and clinic waiting times again improving patient experience, some of which will be very visible to visitors. We will also review the important initiative of 'Mouth Care Matters' although performance will be more difficult to measure.

In terms of last year's indicators the governors welcome the results demonstrating reduced investigation times and the proactive auditing of our procedures to see how they comply with NICE clinical guidelines and quality standards, we look forward to continuing to monitor the improvements to signage and walkways.

Additionally we appreciate the actions being taken to improve patient care and safety, in particular the ongoing work, training and support regarding the very important area of safeguarding. The report details many initiatives and improvements taking place throughout the Trust, which include continued improvements to our catering, to ensure both patients and visitors will have a safer and better experience during their time with the Trust. Of course our staff play a most vital role in providing outstanding care to patients with the consequence that feedback from patients is amongst the best in the country. The Council of governors is extremely grateful for and proud of all the work undertaken by our staff including in respect of their support for our quality accounts.

West Sussex Health and Adult Social Care Overview and Scrutiny Committee

West Sussex HASC Overview and Scrutiny Committee chose not to comment on this quality account as they had not been involved in any significant work with QVH in 2016/17.

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Auditor's report and certificate

KPMG

Independent auditor's report

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

Opinions and conclusions arising from our audit

1. Our opinion on the financial statements is unmodified

We have audited the financial statements of Queen Victoria Hospital NHS Foundation Trust for the year ended 31 March 2017 set out on pages 8 to 34 of the annual accounts. In our opinion:

- the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2017 and of the Trust's income and expenditure for the year then ended; and
- the Trust's financial statements have been properly prepared in accordance with the Department of Health's Group Accounting Manual 2016/17.

Overview		
Materiality: Financial statements as a whole	£1.30m (2015/16: £1.25m)	
	1.95% (2015/16: 2.00%) of total income from operations	
Risks of material misstatement		**vs 2015/16**
Recurring risk	Valuation of land and buildings	◀▶
	Recognition of NHS revenue	◀▶

2. Our assessment of risks of material misstatement

In arriving at our audit opinion above on the financial statements, the risks of material misstatement that had the greatest effect on our audit, in decreasing order of audit significance:

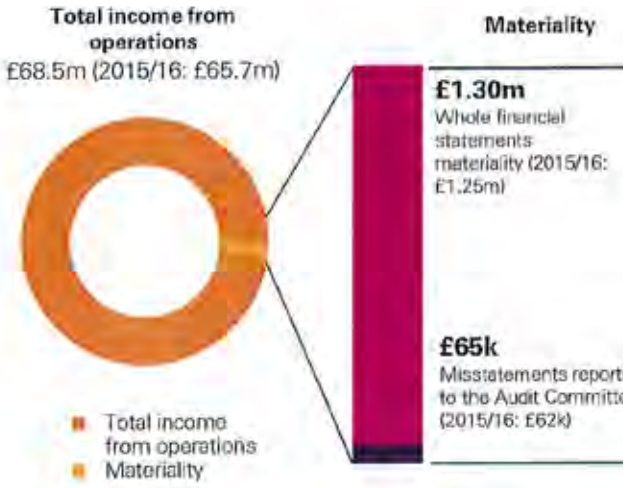
	The risk	Our response
Valuation of land and buildings (£37.2 million; 2015/16: £35.9 million) *Refer to page 46 (Audit Committee Report in the Annual Report), page 12 (accounting policy in the annual accounts) and page 25 (financial disclosures in the annual accounts).*	Land and buildings are required to be held at fair value. The Trust's main land and buildings relate to the site at Queen Victoria Hospital, East Grinstead. Land and buildings are required to be maintained at up to date estimates of year-end market value in existing use (EUV) for non-specialised property assets in operational use, and, for specialised assets where no market value is readily ascertainable, the depreciated replacement cost of a modern equivalent asset that has the same service potential as the existing property (MEAV). There is significant judgment involved in determining the appropriate basis (EUV or MEAV) for each asset according to the degree of specialisation, as well as over the assumptions made in arriving at the valuation and the condition of the asset. In particular, the MEAV basis requires an assumption as to whether the replacement asset would be situated on the existing site or, if more appropriate, on an alternative site, with a potentially significant effect on the valuation. The Trust values land and non specialised buildings using the MEAV valuation methodology, and values specialised assets using the depreciation replacement cost methodology. The Trust undertakes the valuation on an alternative site valuation basis to reflect that if a modern equivalent hospital were rebuilt, it would be rebuilt in a 2 – 3 storey design, in an area more centrally located within its surrounding area. The valuation is completed by an external expert, Gerald Eve, engaged by the Trust using construction indices and so accurate records of the current estate are required. Full valuations are required to be completed every five years, with interim desktop valuations completed in interim periods. Valuations are inherently judgmental, therefore our work focused on whether the valuer's methodology, assumptions and underlying data, are appropriate and correctly applied.	Our procedures included: — **Assessment of external valuer:** We assessed the competence, capability, objectivity and independence of the Trust's external valuer and consider the terms of engagement of, and the instructions issued to, the valuer for consistency with the requirements of the Department of Health's Group Accounting Manual 2016/17; — **Review of asset records:** We considered the accuracy of the estate base data provided to the valuer to complete the desktop valuation to ensure it accurately reflected the Trust estate; — **Assessment of valuation assumptions:** We critically assessed the appropriateness of the valuation bases and assumptions applied to a sample of material assets subject to the revaluation exercise by reference to property records held by the Trust on the condition of the assets, the basis of ownership and the basis of their use; — **Impairment review:** We considered how management and the Trust's valuer had assessed the need for any impairment across its asset base either due to loss of value or reduction in future benefits that would be achieved; and — **Assessing disclosures:** We considered the adequacy of the disclosures about the key judgments and degree of estimation involved in arriving at the valuation and the related sensitivities with reference to the Group Accounting Manual 2016/17.

2. Our assessment of risks of material misstatement (continued)

	The risk	Our response
Recognition of NHS revenue (£60.4 million; 2015/16 £57.9 million) *Refer to page 46 (Audit Committee Report in the Annual Report), page 12 (accounting policy) and page 20 (financial disclosures).*	In 2016/17 the Trust reported income of £60.4m (2015/16: £57.9m) relating to contracts with NHS commissioners. The Trust participates in the Agreement of Balances (AoB) exercise which is mandated by the Department of Health (DH), covering the English NHS only, for the purpose of ensuring that intra-NHS balances are eliminated on the consolidation of the DH resource account. The AoB exercise identifies mismatches between income and expenditure and receivable and payable balances recognised by the Trust and its counter parties at the balance sheet date. Mismatches can occur for various reasons, but the most significant arise where the Trust and commissioners are yet to validate the level of estimated accruals for completed healthcare spells which have not yet been invoiced, accruals for non-contracted out-of-area treatments are not recognised by commissioners or potential contract penalties for non-performance are yet to be finalised. Where there is a lack of agreement, mismatches can be classified as formal disputes and referred to NHS England Area Teams for resolution. In 2016/17 the Department of Health introduced the Sustainability and Transformation Fund (STF), enabling Trusts to secure additional funding upon achievement of specified financial and operational targets. In 2016/17 the Trust secured £1.7m of STF funding, representing achievement of all four quarterly targets and a bonus element.	Our procedures included: — **Contract agreement:** For the five largest commissioners of the Trust's activity we agreed that signed contracts were in place; — **Income billing:** We agreed through testing a sample of invoices that they had been issued in line with the contracts signed with the Trust's five largest commissioners; — **Contract variations:** We tested a sample of contract variations between the Trust and commissioners at the end of the year of actual activity; — **Agreement of Balances exercise**: We assessed the outcome of the AoB exercise. Where there were mismatches over £250,000 we obtained evidence to support the Trust's reported income figure; and — **Sustainability and Transformation Fund (STF) income:** Assessing the Trust's reporting and accounting for STF income received from the Department of Health.

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

The materiality for the financial statements was set at £1.30 million (2015/16: £1.25 million), determined with reference to a benchmark of income from operations (of which it represents approximately 1.95%). We consider income from operations to be more stable than a surplus-related benchmark. We report to the Audit Committee any corrected or uncorrected misstatements identified exceeding £65k (2015/16: £62k), in addition to other identified misstatements that warrant reporting on qualitative grounds.



4. Our opinion on other matters prescribed by the Code of Audit Practice is unmodified

In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2016/17; and
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

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

We are required to report to you if, based on the knowledge we acquired during our audit, we have identified information in the Annual Report that contains a material inconsistency with either that knowledge or the financial statements, a material misstatement of fact, or that is otherwise misleading.

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

- we have identified material inconsistencies between the knowledge we acquired during our audit and the Directors' Statement that they consider that the Annual Report and financial statements taken as a whole is fair, balanced and understandable; or
- the Audit Committee's commentary on page 46 of the Annual Report does not appropriately address matters communicated by us to the Audit Committee.

Under the Code of Audit Practice 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 2016/17, 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.
- the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

In addition we are required to report to you if:

- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.
- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

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

6. We have completed our audit

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

Scope and responsibilities

As described more fully in the Statement of Accounting Officer's Responsibilities on page 1 of the annual accounts the accounting officer is responsible for the preparation of financial statements that give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the UK Ethical Standards for Auditors. A description of the scope of an audit of financial statements is provided on our website at www.kpmg.com/uk/auditscopeother2014. This report is made subject to important explanations regarding our responsibilities, as published on that website, which are incorporated into this report as if set out in full and should be read to provide an understanding of the purpose of this report, the work we have undertaken and the basis of our opinions.

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General, as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

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

Neil Hewitson for and on behalf of KPMG LLP
Chartered Accountants and Statutory Auditor
15 Canada Square, Canary Wharf, London, E14 5GL

26 May 2017

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Annual Accounts 2016/17

"The Trust formulated and delivered plans to address significant cost pressures that emerged during the year and delivered an operational surplus of c£2.2m."

Foreword to the accounts

These accounts for the year ended 31 March 2017 have been prepared by Queen Victoria Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 within the National Health Service Act 2006.

These accounts are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Steve Jenkin
Chief Executive
23 May 2017

Statement of comprehensive income

STATEMENT OF COMPREHENSIVE INCOME FOR THE PERIOD ENDED 31 MARCH 2017			
	Notes	**2016/17 £000**	2015/16 £000
Operating income	3,4	**68,532**	65,723
Operating expenses	5-7	**(65,291)**	(63,104)
Operating surplus		**3,241**	2,619
Finance costs			
Finance income	10	**15**	23
Finance expense – unwinding of discount on provisions	19	**(1)**	(8)
Finance expense – other	20	**(217)**	(240)
PDC dividends payable		**(1,125)**	(948)
Net finance costs		**(1,328)**	(1,173)
RETAINED SURPLUS FOR THE YEAR		**1,913**	1,446
Other comprehensive income (See statement of changes in taxpayers' equity on page 122)			
Revaluation gains on property, plant and equipment	12	**2,162**	3,916
Impairment through revaluation reserve	12	**(766)**	(229)
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**3,309**	5,133

The notes on pages 124 to 130 form part of these accounts.

Statement of financial position

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2017			
	Notes	**31 March 2017 £000**	31 March 2016 £000
NON-CURRENT ASSETS			
Intangible assets	11	**410**	668
Property, plant and equipment	12	**43,869**	42,920
Total non-current assets		**44,279**	43,588
CURRENT ASSETS			
Inventories	14	**429**	439
Trade and other receivables	15	**7,383**	5,846
Cash and cash equivalents	16	**7,784**	7,285
Total current assets		**15,596**	13,570
CURRENT LIABILITIES			
Trade and other payables	17	**(6,787)**	(5,721)
Borrowings	21.1	**(778)**	(778)
Provisions	19	**(43)**	(140)
Other liabilities	18	**(164)**	(1,014)
Total current liabilities		**(7,772)**	(7,653)
NON-CURRENT LIABILITIES			
Provisions	19	**(641)**	(574)
Long term borrowings	21.1	**(6,600)**	(7,378)
Total non-current liabilities		**(7,241)**	(7,952)
TOTAL ASSETS EMPLOYED		**44,862**	41,553
TAXPAYERS' EQUITY (See statement of changes in taxpayers' equity on page 122)			
Public dividend capital		**12,237**	12,237
Revaluation reserve		**10,011**	9,143
Income and expenditure reserve		**22,614**	20,173
TOTAL TAXPAYERS' EQUITY		**44,862**	41,553

The accounts on pages 120 to 123 were approved by the Board on 18 May 2017 and are signed on the Board's behalf by:

Steve Jenkin
Chief Executive
23 May 2017

The notes on pages 124 to 130 form part of these accounts.

Statement of changes in taxpayers' equity

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

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY				
2015/16	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	**Total £000**
Taxpayers' equity at 1 April 2015	12,237	5,801	18,382	**36,420**
Retained Surplus for the year	-	-	1,446	**1,446**
Revaluation of property, plant and equipment	-	3,916	-	**3,916**
Impairments	-	(229)	-	**(229)**
Other reserves movements	-	(345)	345	**-**
Taxpayers' equity at 31 March 2016	12,237	9,143	20,173	**41,533**

The notes on pages 124 to 130 form part of these accounts.

Statement of cash flows

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2017			
	Notes	**2016/17 £000**	2015/16 £000
Operating surplus		**3,241**	2,619
Non-cash income and expense			
Depreciation and amortisation	5	**2,707**	2,573
Impairments	5	**1,072**	1,383
Reversal of impairments	4	**-**	(2,062)
Non-cash donations credited to income	4	**(18)**	(50)
Decrease in inventories	14	**10**	1
(Increase)/decrease in trade receivables	15	**(1,589)**	2,557
Increase/(decrease) in trade and other payables	17	**491**	(1,155)
Decrease in provisions	19	**(31)**	(221)
Increase/(decrease) in other liabilities	18	**(850)**	578
Other movements in operating cash flows		**-**	67
Net cash inflow from operations		**5,033**	6,290
Cash flows from investing activities			
Interest received	10	**15**	23
Payments to acquire intangible assets	11	**(5)**	(21)
Payments to acquire property, plant and equipment	12	**(2,487)**	(3,528)
Net cash used in investing activities		**(2,477)**	(3,526)
Cash flows from financing activities			
Loans repaid to the Independent Trust Financing Facility	21.1	**(778)**	(778)
Interest paid	20	**(224)**	(240)
PDC dividends paid		**(1,055)**	(1,009)
Net cash used in financing activities		**(2,057)**	(2,027)
Increase in cash		**499**	737
Cash and cash equivalents at 1 April	16	**7,285**	6,548
Cash and cash equivalents at 31 March	16	**7,784**	7,285

The notes on pages 124 to 130 form part of these accounts.

Notes to the financial statements

1 Accounting policies

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the Secretary of State. Consequently, the financial statements have been prepared in accordance with the DH GAM 2016/17 issued by the Department of Health. The accounting policies contained in that manual follow IFRS and HM Treasury's FReM to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

1.1 Income

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

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

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

1.2 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

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

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

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

1.3 Expenditure on other goods and services

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

1.4 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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

Measurement

Valuation

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

To this end, valuations of land, buildings and fixtures are carried out by professionally qualified 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 2017 as at the prospective valuation date of 31 March 2017 and were accounted for in the 2016/17 accounts.

Fair values are determined as follows:

Land and non-specialised buildings – market value for existing use.

Specialised buildings – depreciated replacement cost

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

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

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

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

Equipment is stated in the Statement of Financial Position at its revalued amount, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the balance sheet date. In the intervening periods the Trust considers depreciated historic cost to be a suitable estimate of fair value.

Subsequent expenditure

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

Depreciation

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

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

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

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust.

Revaluation and impairment

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

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

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

An impairment arising from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

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

Land and buildings were revalued as at 31 March 2017.

The revaluation was carried out by an independent, qualified valuer on the modern equivalent asset basis and the assumption that the property is sold as part of the continuing enterprise in occupation. The valuation was based on the use of an alternative site.

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

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

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

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

Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.5 Intangible assets

Recognition

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

Internally generated intangible assets

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

Expenditure on research is not capitalised.

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

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

Software

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

Measurement

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

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

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

Amortisation

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

1.6 Inventories

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

1.7 Cash and cash equivalents

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

1.8 Trade receivables

Trade receivables are recognised at fair value less provision for impairment. A provision for impairment of trade receivables is established when there is objective evidence that the Trust will not be able to collect all amounts due according to the original terms of the receivables. Significant financial difficulties of the debtor, probability that the debtor will enter bankruptcy or financial reorganisation, and default or delinquency in payments (more than 60 days overdue) are considered indicators that the trade receivable is impaired. The amount of the provision is the difference between the asset's carrying amount and the estimated future cash flows. The carrying amount of the asset is reduced through the use of a provision for doubtful debts account, and the amount of the loss is recognised in the 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 cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

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

Classification and measurement

Financial assets are categorised as 'Loans and Receivables'.

Financial liabilities are classified as 'Financial Liabilities'.

Loans and receivables

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

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

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

Financial liabilities

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

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

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows 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 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 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 Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 19. The Trust does not carry any amounts relating to these cases in its own accounts.

Other NHSLA schemes

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

1.13 Contingencies

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

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

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

1.14 Public dividend capital

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

A charge, reflecting the cost of capital utilised by theTrust, 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 2017.

1.17 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

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

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

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

1.18 IASB standard and IFRIC interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2016/17.

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

i) IFRS 9 - Financial Instruments .
Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

ii) IFRS 14 - Regulatory Deferral Accounts
Not yet adopted by the EU. Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DH group bodies.

iii) IFRS 15 - Revenue from Contracts with Customers
Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

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

1.19 Critical accounting estimates and assumptions

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

Value of land and buildings £37,170,000 (2015/16 £35,934,000) - This is the most significant estimate in the accounts and is based on the professional judgement of the Trust's independent valuer with extensive knowledge of the physical estate and market factors. The value does not take into account potential future changes in market value which cannot be predicted with any certainty.

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

Income for an inpatient stay can start to be recognised from the day of admission, but cannot be precisely calculated until after the patient is discharged. For patients occupying a bed at the 2016/17 financial year end, the estimated value of partially completed spells is £61,000 (2015/16 £174,000).

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

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

1.20 Operating segments

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

The Trust derives its income from the provision of healthcare, chiefly in its capacity as a specialist provider of various forms of reconstructive surgery. All services are subject to the same policies, procedures and governance arrangements. They are also subject to the same regulatory environment and standards set by our external performance managers. Accordingly, the trust operates one segment.

1.21 Consolidation of accounts

The Trust is the corporate trustee to the Queen Victoria Hospital NHS Trust Charitable Fund and as such has the power to govern its financial and operating policies so as to obtain benefits from its activities for itself, its patients or its staff. In 2013/14 the Trust was expecting the charity to grow substantially in the succeeding years and therefore determined it to be a material subsidiary. Consolidated accounts were prepared from 2013/14 onwards. In the event, the size of the charity has declined over the years, causing the Trust to re-assess its policy in regard to materiality and consolidation. It has decided that it is no longer appropriate to consolidate the accounts of the Trust and the Charity, and these accounts therefore relate solely to the Trust.

1.22 Third party assets

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

1.23 Pensions

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

Employer's pension cost contributions are charged to operating expenses as and when they become due.

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

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

2. Operating segments

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

	2016/17 £000	2015/16 £000
Income	**68,532**	65,723
Segment surplus	**1,913**	1,446
Segment net assets	**44,862**	41,553

3. Income from patient care activities

	2016/17 £000	2015/16 £000
Clinical commissioning groups and NHS England	**60,378**	57,925
Other NHS bodies	**168**	187
Private patients	**92**	175
Injury costs recovery	**334**	253
Other	**630**	704
	61,602	59,244

Notes:

'Injury costs recovery' is income received through the NHS injury scheme from insurance companies in relation to the treatment of patients who have been involved in road traffic accidents. It is subject to a provision for impairment of receivables of 22.94% to reflect expected rates of collection.

Commissioner requested services

Within the 2016/17 financial statements management has taken the view that commissioner requested services are those which are provided for the healthcare of NHS patients. There is ongoing discussion between management and commissioners on the formal agreement of the definition of commissioner requested services.

Of the total income reported above, £61,510,000, (2015/16 £59,069,000) was derived from the provision of commissioner requested services.

4. Other operating income

	2016/17 £000	2015/16 £000
Education and training	**1,656**	1,487
Charitable and other contributions	**18**	182
Non-patient care services to other bodies	**2,482**	1,704
Sustainability and Transformation Fund	**1,673**	n/app
Reversal of impairments	**-**	2,062
Other income	**1,101**	1,044
	6,930	6,479

5. Operating expenses

	2016/17 £000	2015/16 £000
Services from NHS foundation trusts	**121**	129
Services from NHS trusts	**9**	-
Purchase of healthcare from non-NHS bodies	**201**	285
Executive directors' costs	**514**	539
Non-executive directors' costs	**105**	111
Staff costs (Excluding directors)	**42,119**	40,785
Consultancy	**32**	43
Drugs	**1,351**	1,382
Supplies and services - clinical (excluding drugs)	**10,304**	8,382
Supplies and services - general	**760**	591
Establishment	**728**	560
Transport	**489**	465
Premises	**3,527**	2,480
Provision for impairment of receivables	**(285)**	408
Depreciation	**2,444**	2,312
Amortisation	**263**	261
External audit – statutory audit	**51**	60
– audit-related assurance services	**8**	10
Internal audit services	**49**	54
Clinical negligence (payments to NHSLA)	**365**	323
Other	**1,064**	2,541
	64,219	61,721
Impairments of property, plant and equipment	**1,072**	1,383
	65,291	63,104

Note

External audit

The contract between the Trust and its auditors provides for the latter's liability to be limited to £1,000,000. External audit fees, exclusive of irrecoverable VAT, were £42,425 for statutory audit and £7,000 for audit related assurance services.

In 2015/16 inventories consumed amounting to £1.4m was included in other, in 2016/17 inventories consumed of £1.3m has been included in supplies and services – clinical. The change in classification is in accordance with the requirements of the DH GAM.

6. Operating leases

As lessee

Operating leases relate to buildings, medical equipment and vehicles.

A building is leased for a remaining period of two years.

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

Payments recognised as an expense	2016/17 £000	2015/16 £000
Minimum lease payments	**303**	373

6. Operating leases (cont.)

Total future minimum lease payments	2016/17 £000	2015/16 £000
Payable:		
Not later than one year	**212**	52
Between one and five years	**216**	647
After five years	**-**	-
Total	**428**	699

7. Employee benefits and staff numbers

7.1 Employee benefits	2016/17 £000	2015/16 £000
Salaries and wages	**33,454**	32,767
Social security costs	**3,406**	2,717
Employer contributions to NHS Pension Scheme	**3,942**	3,912
Agency/contract staff	**2,947**	2,376
Employee benefits expense	**43,749**	41,772
Recoveries in respect of seconded staff	**(447)**	(448)
Costs capitalised as part of assets	**(669)**	-
Total staff costs excluding capitalised costs	**42,633**	41,324

7.2 Average number of people employed	2016/17 Trust Number	2015/16 trust Number
Medical and dental	**144**	140
Administration and estates	**247**	243
Healthcare assistants and other support staff	**121**	126
Nursing, midwifery and health visiting staff	**172**	187
Scientific, therapeutic and technical staff	**59**	159
Healthcare science staff	**102**	-
Agency and contract staff	**32**	30
Bank staff	**34**	29
Total	**911**	914
Of which - Number of employees (WTE) engaged on capital projects	**7**	

7.3 Directors' remuneration

Gross salary costs for directors included in note 7.1 for the year ended 31/03/2017 (in their capacity as directors) totalled £619,000 (2015/16 £650,000). 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 31/03/2017 totalled £80,000 (2015/16 £70,000). The total number of directors to whom benefits are accruing under the NHS defined benefit scheme (the NHS Pension Scheme) was six.

7.4 Staff exit packages for staff leaving in 2016/17

Staff exit packages are payable when the Trust terminates the employment of an employee before the normal retirement date or whenever an employee accepts compulsory redundancy in return for these benefits. During the year there was one case in which contractual payments were made in lieu of notice and one case of compulsory redundancy.

Exit package cost band	**2016/17**		2015/16	
£000	**Number of exit packages**	**Total exit packages by cost band**	Number of exit packages	Total exit packages by cost band
10–25 (payment in lieu of notice)	**1**	**1**	-	-
50–100 (compulsory redundancies)	**1**	**1**	-	-
Total	**2**	**2**	-	-

8. Retirements due to ill-health

During the year there were no early retirements due to ill health at a cost to the NHS pension scheme of £0 (2015/16, 1 at a cost to the NHS pension scheme of £115,000).

9. Pensions costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

10. Finance income

	2016/17 £000	2015/16 £000
Interest from bank accounts	**15**	23

11. Intangible assets

Software licences	2016/17 £000	2015/16 £000
Gross cost at 1 April	**1,528**	1,574
Additions	**5**	21
Disposals	**-**	(67)
Gross cost at 31 March	**1,533**	1,528
Amortisation at 1 April	**860**	599
Provided during the year	**263**	261
Amortisation at 31 March	**1,123**	860
Net book value		
Purchased assets at 1 April	**668**	975
Purchased assets at 31 March	**410**	668

12. Property, plant and equipment – group and trust

12.1 Property, plant and equipment at 31 March 2017	Land £000	Buildings £000	Assets under construction £000	Plant and machinery £000	Information technology £000	Total £000
Cost or valuation at 1 April 2016	4,140	31,794	3,339	12,455	2,234	**53,962**
Additions - purchased	-	924	1,371	745	11	**3,051**
Additions - donated	-	-	-	12	6	**18**
Reclassifications	-	1,206	(2,856)	-	1,650	**-**
Impairments recognised in operating expenses	(208)	(1,463)	-	-	-	**(1,671)**
Reversal of impairments	-	599	-	-	-	**599**
Impairments recognised in revaluation reserve	(2)	(764)	-	-	-	**(766)**
Revaluation	-	2,162	-	-	-	**2,162**
Accumulated depreciation transferred on revaluation	-	(1,218)	-	-	-	**(1,218)**
Disposals	-	-	-	-	-	**-**
At 31 March 2017	**3,930**	**33,240**	**1,854**	**13,212**	**3,901**	**56,137**
Depreciation at 1 April 2016	-	-	-	9,184	1,858	**11,042**
Provided during the year	-	1,218	-	985	241	**2,444**
Accumulated depreciation transferred on revaluation	-	(1,218)	-	-	-	**(1,218)**
Disposals	-	-	-	-	-	**-**
Depreciation at 31 March 2017	**-**	**-**	**-**	**10,169**	**2,099**	**12,268**
Net book value						
Purchased assets as at 1 April 2016	4,140	29,583	3,339	2,897	356	**40,315**
Donated assets as at 1 April 2016	-	2,211	-	374	20	**2,605**
Total at 1 April 2016	**4,140**	**31,794**	**3,339**	**3,271**	**376**	**42,920**
Purchased assets as at 31 March 2017	3,930	31,222	1,854	2,779	1,783	**41,568**
Donated assets as at 31 March 2017	-	2,018	-	264	19	**2,301**
Total at 31 March 2017	**3,930**	**33,240**	**1,854**	**3,043**	**1,802**	**43,869**

12.1 Property, plant and equipment (continued)						
2015/16 comparators	**Land £000**	**Buildings £000**	**Assets under construction £000**	**Plant and machinery £000**	**Information technology £000**	**Total £000**
Cost or valuation at 1 April 2015	3,050	30,198	225	12,395	2,175	**48,043**
Additions - purchased	-	136	3,547	344	59	**4,086**
Additions - donated	-	50	-	-	-	**50**
Reclassifications	-	433	(433)	-	-	**-**
Impairments recognised in operating expenses	-	(1,383)	-	-	-	**(1,383)**
Reversal of impairments	1,088	974	-	-	-	**2,062**
Impairments recognised in revaluation reserve	-	(229)	-	-	-	**(229)**
Revaluation	2	3,914	-	-	-	**3,916**
Accumulated depreciation transferred on revaluation	-	(2,299)	-	-	-	**(2,299)**
Disposals	-	-	-	(284)	-	**(284)**
At 31 March 2016	**4,140**	**31,794**	**3,339**	**12,455**	**2,234**	**53,962**
Depreciation at 1 April 2015	-	**1,130**	-	8,506	1,677	**11,313**
Provided during the year	-	**1,169**	-	962	181	**2,312**
In-year depreciation transferred on revaluation	-	**(2,299)**	-	-	-	**(2,299)**
Disposals	-	-	-	(284)	-	**(284)**
Depreciation at 31 March 2016	**-**	**-**	**-**	**9,184**	**1,858**	**11,042**
Net book value						
- Purchased assets as at 1 April 2015	3,050	26,910	225	3,373	471	**34,029**
- Donated assets as at 1 April 2015	-	2,158	-	516	27	**2,701**
Total at 1 April 2015	**3,050**	**29,068**	**225**	**3,889**	**498**	**36,730**
- Purchased assets as at 31 March 2016	4,140	29,583	3,339	2,897	356	**40,315**
- Donated assets as at 31 March 2016	-	2,211	-	374	20	**2,605**
Total at 31 March 2016	**4,140**	**31,794**	**3,339**	**3,271**	**376**	**42,920**

12.2 Fully depreciated assets

Fully depreciated assets with an aggregate gross carrying value of £9,183,000 were in use at 31 March 2017.

12.3 Property, plant and equipment donated during the year

The League of Friends of the Queen Victoria Hospital donated three capital items with a combined value of £18,000.

13. Capital commitments

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

Capital commitments	**31 March 2017 £000**	31 March 2016 £000
Property, plant and equipment	**193**	1,123

14. Inventories

Inventories at 31 March	31 March 2017 £000	31 March 2016 £000
Drugs	**109**	108
Consumables	**320**	331
Total	**429**	439

15. Trade and other receivables

15.1 Trade and other receivables comprise	31 March 2017 Current £000	31 March 2016 Current £000
NHS and other related party receivables	**2,727**	3,547
Accrued income	**3,392**	1,823
Provision for the impairment of receivables	**(798)**	(1,224)
Prepayments	**617**	355
Other receivables	**1,445**	1,345
Total	**7,383**	5,846

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

15.2 Receivables past their due date but not impaired	31 March 2017 £000	31 March 2016 £000
By up to three months	**986**	637
By between three and six months	**465**	185
By more than six months	**661**	484
Total	**2,112**	1,306

15.3 Provision for impairment of NHS receivables	31 March 2017 £000	31 March 2016 £000
Balance at 1 April 2016	**(908)**	(730)
Amount recovered or written off during the year	**516**	492
Increase in receivables impaired	**(112)**	(670)
Balance at 31 March 2017	**(504)**	(908)

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

15.4 Provision for impairment of non-NHS receivables	31 March 2017 £000	31 March 2016 £000
Balance at 1 April 2016	**(316)**	(86)
Amount recovered or written off during the year	**58**	111
Increase in receivables impaired	**(36)**	(341)
Balance at 31 March 2017	**(294)**	(316)

16. Cash and cash equivalents

	31 March 2017 £000	31 March 2016 £000
Balance at 1 April 2016	**7,285**	6,548
Net change in year	**499**	737
Balance at 31 March 2017	**7,784**	7,285
Comprising:		
Cash with the Government Banking Service (GBS)	**7,739**	7,265
Commercial banks and cash in hand	**45**	20
Cash and cash equivalents as in statement of cash flows	**7,784**	7,285

17. Trade and other payables

	31 March 2017 £000	31 March 2016 £000
NHS payables	**2,667**	1,380
Trade payables – capital	**1,202**	638
Other payables – revenue	**805**	1,061
Accruals	**1,226**	1,803
	5,900	4,882
Tax and social security costs	**887**	839
Total	**6,787**	5,721

NHS payables include £557,000 outstanding pensions contributions at 31 March 2017 (31 March 2016 £562,000).

18. Deferred income

Current	31 March 2017 £000	31 March 2016 £000
Total	**164**	1,014

19. Provisions

Current	31 March 2017 £000	31 March 2016 £000
Pensions relating to staff	**27**	27
Legal claims	**16**	6
Contract provision	**-**	107
Total	**43**	140

Non-current	31 March 2017 £000	31 March 2016 £000
Pensions relating to staff	**641**	574

Movements in-year	Pensions relating to staff £000	Legal claims £000	Contract provision £000	Total £000
At 1 April 2016	601	6	107	**714**
Change in discount rate	84	-	-	**84**
Arising during the year	10	10	-	**20**
Used during the year	(28)	-	-	**(28)**
Reversed unused	-	-	(107)	**(107)**
Unwinding of discount	1	-	-	**1**
At 31 March 2017	668	16	-	**684**

Expected timing of cash flows:				
Within one year	27	16	-	**43**
Between one and five years	99	-	-	**99**
After five years	542	-	-	**542**
	668	16	-	**684**

The provision for pensions relating to staff consists of £618,000 in respect of injury benefit (31 March 2016 £553,000) and £50,000 in respect of early retirements (31 March 2016 £48,000). The amounts represent the discounted future value of annual payments made to the NHS Pensions Agency calculated on an actuarial basis.

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

£2,491,000 was included in the provisions of the NHS Litigation Authority at 31 March 2017 in respect of clinical negligence liabilities of the Trust (31 March 2016 £2,039,000).

20. Finance expense

Interest expense	31 March 2017 £000	31 March 2016 £000
Loans from the Foundation Trust Financing Facility (Department of Health)	**217**	240

21. Financial instruments

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

Financial Instruments are recognised and measured in accordance with the accounting policy described under Note 1.10.

21.1 Financial assets and liabilities by category

All financial assets and liabilities are denominated in sterling.

Financial assets	**31 March 2017 £000**	31 March 2016 £000
Loans and receivables:		
NHS and other related party receivables	**2,727**	2,323
Accrued income	**3,392**	1,823
Other receivables	**1,416**	1,151
Cash at bank and in hand	**7,784**	7,285
Total	**15,319**	12,582

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 2017 £000**	31 March 2016 £000
Carrying value:		
Borrowings	**7,378**	8,156
Trade and other payables	**4,563**	2,992
Accrued expenditure	**1,208**	1,803
Total	**13,149**	12,951

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

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

Other tax and social security cost amounts of £887,000 (2015/16 £839,000) and deferred income of £164,000 (2015/16 £1,014,000) are not classed as financial instruments and have therefore been excluded from the above analysis.

21.2 Maturity of financial assets

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

21.3 Maturity of financial liabilities

All of the Trust's financial liabilities fall due within one year with the exception of the £6,600,000 portion of the borrowings that falls due after more than one year.

21.4 Derivative financial instruments

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

21.5 Financial risk management

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

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

Currency risk

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

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposure as at 31 March 2017 are in receivables from customers, as disclosed in note 15.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust is not, therefore, exposed to significant liquidity risks.

22. Related party transactions

No board members or members of the key management staff or parties related to them undertook any transactions with Queen Victoria Hospital NHS Foundation Trust during 2016/17 (2015/16 none).

The Department of Health is the parent department, other public sector bodies included within the Whole of Government Accounts are also deemed to be related parties. The Trust has financial transactions with many such bodies.

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

The total income and expenditure transactions with the charity and the receivable and payable balances with it at the year end are shown below.

	2016/17		2015/16	
	Income £000	**Expenditure £000**	Income £000	Expenditure £000
The Queen Victoria Hospital NHS Trust Charitable Fund	**30**	**-**	28	-

	2016/17		31 March 2016	
	Receivables £000	**Payables £000**	Receivables £000	Payables £000
The Queen Victoria Hospital NHS Trust Charitable Fund	**-**	**2**	3	-

Whole of Government Accounts bodies	**2016/17**		2015/16	
Bodies with whom either income or expenditure exceeded £150,000 during the year:	**Income £000**	**Expenditure £000**	Income £000	Expenditure £000
Income and expenditure				
Brighton and Sussex University Hospitals NHS Trust	**194**	**951**	89	980
Guy's and St Thomas' NHS Foundation Trust	**100**	**14**	154	10
Maidstone and Tunbridge Wells NHS Trust	**158**	**82**	223	82
Dartford and Gravesham NHS Trust	**-**	**751**	7	721
Medway NHS Foundation Trust	**30**	**1,039**	29	911
East Sussex Hospitals NHS Trust	**-**	**600**	24	754
Sussex Community NHS Foundation Trust	**190**	**13**	84	13
NHS Litigation Authority	**-**	**365**	-	323
Health Education England	**1,651**	**4**	1,395	-
NHS England	**23,127**	**8**	22,337	-
NHS Ashford CCG	**462**	**-**	526	-
NHS Bexley CCG	**412**	**-**	476	-
NHS Brighton and Hove CCG	**1,086**	**-**	1,060	-
NHS Bromley CCG	**608**	**-**	559	-
NHS Canterbury and Coastal CCG	**712**	**-**	749	-
NHS Coastal West Sussex CCG	**2,570**	**-**	2,140	-
NHS Crawley CCG	**1,930**	**-**	1,555	-
NHS Croydon CCG	**235**	**-**	274	-
NHS Dartford Gravesham and Swanley CCG	**2,570**	**-**	2,374	-
NHS East Surrey CCG	**2,577**	**-**	2,723	-
NHS Eastbourne Hailsham and Seaford CCG	**1,120**	**-**	1,237	-
NHS Guildford and Waverley CCG	**510**	**-**	593	-
NHS Hastings and Rother CCG	**1,746**	**-**	1,627	-
NHS High Weald Lewes Havens CCG	**3,697**	**-**	3,295	107
NHS Horsham and Mid Sussex CCG	**6,284**	**-**	5,318	-
NHS Medway CCG	**2,727**	**-**	2,331	-
NHS North West Surrey CCG	**228**	**-**	151	-
NHS South Kent Coast CCG	**743**	**-**	702	-
NHS Surrey Downs CCG	**798**	**-**	816	-
NHS Swale CCG	**1,060**	**-**	1,122	-
NHS Thanet CCG	**416**	**-**	375	-
NHS West Kent CCG	**5,769**	**-**	5,310	-
	63,710	**3,827**	59,655	3,901

22. Related party transactions (cont.)

	31 March 2017		31 March 2016	
	Receivables £000	**Payables £000**	Receivables £000	Payables £000
Receivables and payables				
Brighton and Sussex University Hospitals NHS Trust	**469**	**590**	466	189
Guy's and St Thomas' NHS Foundation Trust	**35**	**9**	93	4
Maidstone and Tunbridge Wells NHS Trust	**135**	**74**	183	23
Dartford and Gravesham NHS Trust	**7**	**92**	7	60
Medway NHS Foundation Trust	**125**	**654**	58	253
East Sussex Healthcare NHS Trust	**-**	**73**	-	133
Sussex Community NHS Foundation Trust	**2**	**7**	-	-
NHS Litigation Authority	**-**	**-**	-	-
Health Education England	**14**	**-**	115	-
NHS England	**1,287**	**339**	1,683	23
NHS Ashford CCG	**49**	**-**	54	-
NHS Bexley CCG	**42**	**-**	-	50
NHS Brighton and Hove CCG	**11**	**-**	-	66
NHS Bromley CCG	**4**	**-**	-	41
NHS Canterbury and Coastal CCG	**-**	**47**	5	6
NHS Coastal West Sussex CCG	**471**	**-**	126	-
NHS Crawley CCG	**248**	**-**	66	-
NHS Croydon CCG	**16**	**4**	-	61
NHS Dartford, Gravesham and Swanley CCG	**17**	**-**	-	122
NHS East Surrey CCG	**-**	**72**	36	-
NHS Eastbourne, Hailsham and Seaford CCG	**-**	**162**	217	-
NHS Guildford and Waverley CCG	**12**	**-**	100	-
NHS Hastings and Rother CCG	**35**	**-**	-	67
NHS High Weald Lewes Havens CCG	**444**	**15**	212	70
NHS Horsham and Mid Sussex CCG	**701**	**-**	345	-
NHS Medway CCG	**70**	**26**	-	78
NHS North West Surrey CCG	**42**	**-**	39	-
NHS South Kent Coast CCG	**26**	**-**	25	-
NHS Surrey Downs CCG	**26**	**14**	5	-
NHS Swale CCG	**18**	**-**	69	-
NHS Thanet CCG	**13**	**-**	-	14
NHS West Kent CCG	**148**	**-**	294	-
	4,467	**2,178**	4,198	1,260

23. Intra-government and other balances

Receivables: amounts falling due within one year	31 March 2017 £000	31 March 2016 £000
Balances with NHS bodies	**5,700**	5,186
Balances with other government bodies	**557**	390
Balances with bodies external to government	**1,924**	1,494
Provision for the impairment of receivables	**(798)**	(1,224)
	7,383	5,846

Payables: amounts falling due within one year	31 March 2017 £000	31 March 2016 £000
Balances with NHS bodies	**2,328**	1,371
Balances with other government bodies	**1,511**	1,473
Balances with bodies external to government	**2,948**	2,877
	6,787	5,721

24. Losses and special payments

Losses and special payments are calculated on an accruals basis.

There were 48 cases of losses and special payments totalling £31,000 approved during 2016/17, (42 cases totalling £4,000 in 2015/16).

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

There were no fraud cases within these losses.

25. Third party assets

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

7

Appendices

7.1 Board of directors register

Name, title and appointment	Meeting attendance and role 2016/17						
	Board of directors	Council of governors	Audit committee	QVH Charity committee	Nomination and remuneration committee	Quality and governance committee	Finance and performance committee
Ginny Colwell* Independent Clinical Adviser 3 March 2016 to 21 April 2016	0 of 1*	1 of 1 attendee	NA	NA	NA	1 of 1** attendee	NA
Non-Executive Director 21 April 2016 to 20 April 2019	10 of 10* member	2 of 3 attendee	4 of 5 member	NA	2 of 3	11 of 11 chair	NA
Stephen Fenlon 1 April 2013 to 30 September 2016	5 of 5 member	2 of 2 attendee	NA	1 of 2 member	NA	4 of 6 member	NA
Beryl Hobson Chair 1 April 2015 to 31 March 2018	11 of 11 chair	4 of 4 chair	1 of 1	4 of 4 member	3 of 3 chair	NA	10 of 11 member
Steve Jenkin Chief Executive 14 November 2016 to present	4 of 4 member	1 of 1 attendee	2 of 2 ex-officio	NA	1 of 1	3 of 4	5 of 5 member
Ed Pickles Medical Director 1 October 2016 to 30 September 2019	6 of 6 member	2 of 2 attendee	NA	2 of 2 member	NA	5 of 6 member	NA
Ian Playford Non-Executive Director 10 April 2015 to 28 October 2016	5 of 6 member	2 of 3 attendee	NA	NA	1 of 2 member	NA	4 of 6 member
Lester Porter Non-Executive Director and Senior Independent Director 1 September 2011 to 31 August 2017	9 of 11 member	4 of 4 attendee	5 of 5 chair	4 of 4 chair	3 of 3 member	9 of 11 member 1 of 1 chair**	NA
Clare Stafford Director of Finance and Performance 1 June 2015 to present	11 of 11 member	4 of 4 attendee	4 of 5 attendee	1 of 4 member	NA	9 of 12 member	10 of 11 member
Jo Thomas Director of Nursing and Quality 1 February 2015 to present	9 of 11 member	4 of 4 attendee	5 of 5 attendee	NA	NA	9 of 12 member	8 of 11 member
John Thornton Non-Executive Director 1 October 2013 to 30 September 2019	9 of 11 member	4 of 4 attendee	4 of 5 member	NA	3 of 3 member	NA	10 of 11 chair
Richard Tyler Chief Executive 1 July 2013 to 13 November 2016	6 of 7 member	2 of 3 attendee	3 of 3 ex-officio	NA	1 of 1 member	3 of 7 member	5 of 6 member

* In February 2016 QVH discovered that Ginny Colwell was not eligible to be a member of Queen Victoria Hospital NHS Foundation Trust because her home address was not, at that time, within one of the electoral wards defined in Annex 1 of the Trust's constitution. Once the flaw in Ginny Colwell's appointment became apparent, legal advice was sought and she was removed from the register of members and the register of directors so as not to leave the Trust in breach of its constitution and licence. Following changes to the constitution that incorporated South London boroughs into the public constituency, Ginny Colwell joined the Trust as a member and at a meeting of the council of governors on 21 April 2016, was appointed non-executive director for a three-year term.

** Further to the removal of Ginny Colwell from the register of members and the register of directors, Lester Porter acted as chair for one meeting of the quality and governance committee.

7.2 Council of governors register

Name	Constituency	Status of current term	Start of term	End of term	Meeting attendance
Beesley, Brian	Public	Re-elected 2nd term	01/07/2014	30/06/2017	4 of 4
Belsey, John	Public	Elected 1st term	01/07/2014	30/06/2017	*3 of 4
Bennett, Liz	Stakeholder[2]	Appointed	01/07/2013	30/06/2017	*2 of 4
Bowers, John	Public	Elected 1st term	01/07/2013	30/06/2016	1 of 1
Burkhill-Prior, Wendy	Public	Elected 1st term	01/07/2016	30/06/2019	3 of 3
Chimonas, Milton[3]	Public	Re-election 2nd term	01/07/2016	30/06/2019	0 of 1
Cunnington, Jenny	Public	Re-elected 2nd term	01/07/2014	30/06/2017	3 of 4
Dabell, John	Public	Re-elected 2nd term	01/07/2014	30/06/2017	4 of 4
Dudgeon, Robert	Public	Re-elected 2nd term	01/07/2016	30/06/2019	4 of 4
Glynn, Angela	Public	Elected 1st term	01/07/2014	30/06/2017	4 of 4
Goode, Brian	Public	Re-elected 2nd term	01/07/2013	30/06/2016	1 of 1
Halloway, Chris	Public	Elected 1st term	01/07/2015	30/06/2018	4 of 4
Harold, John	Public	Elected 2nd term	01/07/2015	30/06/2018	4 of 4
Higgins, Anne	Public	Re-elected 2nd term	01/07/2014	30/06/2017	3 of 4
Martin, Tony	Public	Elected 1st term	01/07/2014	30/06/2017	3 of 4
McMillan, Moira	Public	Re-elected 2nd term	01/07/2013	30/06/2016	0 of 1
Mockford, Julie	Staff	Elected 1st term	01/07/2014	30/06/2017	*3 of 4
Orman, Christopher	Public	Re-elected 2nd term	01/07/2014	30/06/2017	3 of 4
Rashid, Mansoor	Staff	Elected 1st term	01/07/2014	30/06/2017	1 of 4
Robertson, Andrew[4]	Stakeholder	Appointed	01/07/2013	30/03/2017	2 of 4
Roche, Glynn	Public	Elected 1st term	01/07/2014	30/06/2017	*2 of 4
Santi, Gillian	Public	Re-elected 2nd term	01/07/2014	30/06/2017	4 of 4
Shaw, Michael	Public	Re-elected 2nd term	01/07/2014	30/06/2017	3 of 4
Shore, Peter	Public	Elected 1st term	01/07/2016	30/06/2019	3 of 3
Smith, Shona	Staff[5]	Elected 1st term	01/07/2014	30/06/2017	*2 of 3
Webster, Norman	Stakeholder[6]	Appointed	01/07/2011	Ongoing	4 of 4
Wickenden, Peter	Public	Re-elected 2nd term	01/07/2014	30/06/2017	3 of 4

* The date of the July council of governors meeting was changed at short notice affecting the attendance of some of its members

2 Representing West Sussex County Council

3 Milton Chimonas was appointed for a second term due to begin on 1 July 2016 but resigned before taking up his position.

4 Representing the League of Friends of Queen Victoria Hospital

5 Shona Smith resigned on 16 November 2016

6 Representing East Grinstead Town Council

7.3 Directors' biographies 2016/17

Ginny Colwell, Non-Executive Director

Ginny originally trained as a nurse and worked at Great Ormond Street Hospital, leaving there as deputy director of nursing to become director of nursing at the Royal Surrey County Hospital. Ginny then became corporate head of nursing for Nuffield Hospitals before being appointed head of nursing for Surrey and Sussex Strategic Health Authority. Ginny has also been a founder non-executive director at Central Surrey Health, acting as chair for her last three months, and vice chair of Phyllis Tuckwell Hospice. Ginny currently works independently as an individual and organisational coach.

Dr Stephen Fenlon, Medical Director

Stephen was QVH's medical director from 1 April 2013 until 30 September 2016 and had also been a consultant anaesthetist at QVH. He qualified in 1988 from Nottingham University Medical School and initially followed a career in general practice before deciding to specialise in anaesthesia. Stephen also held various managerial positions at QVH, including lead clinician for paediatric services and, clinical director for paediatrics and clinical support services. Stephen was succeeded as medical director by Dr Ed Pickles (see below).

Beryl Hobson, Chair

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

Steve Jenkin, Chief Executive

Steve Jenkin joined the QVH in November 2016, succeeding Richard Tyler. Before joining QVH Steve was the chief executive of Peninsula Community Health, an organisation which provides services across Cornwall and runs 14 community hospitals. Prior to that Steve has been director of health and social care with national charity Sue Ryder, and chief executive of Elizabeth FitzRoy Support, a national charity supporting people with learning disabilities. Steve has an MBA through the Open University.

Dr Ed Pickles, Medical Director

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

Ian Playford, Non-Executive Director

Ian Playford was a non-executive director from April 2015 until October 2016. He was also a non-executive director of Her Majesty's Courts and Tribunal Service, board adviser to Kingsbridge Estates and ran OnBoard Executive Ltd a company providing strategic, investment and coaching advice to organisations. At QVH Ian was a member of the finance and performance committee. He left to take up a role a new role in which he was no longer able to give the time needed to his QVH role.

Lester Porter, Non-Executive Director and Senior Independent Director

Lester Porter was appointed in September 2011.He has his own executive coaching practice working with individual executives and company boards. Lester's experience includes 15 years as an 'angel' investor in start-up businesses and chair and non-executive director positions on the boards of a number of these companies. From 2006 until 2013 he was chair of an £800 million pension fund. Previously, Lester spent 30 years in a variety of management roles in the healthcare, publishing, financial services and travel sectors and was latterly with the Thomas Cook Group as corporate development director. At QVH Lester also chairs the audit committee and the charity committee.

Clare Stafford, Director of Finance and Performance

Clare was appointed in June 2015 from West Hertfordshire Hospitals NHS Trust where she was director of operational finance and efficiency. Clare has worked in the NHS for 20 years, having begun her career on the NHS financial management training scheme. During her career she has worked in senior finance roles at Hertfordshire Partnership NHS Trust and Barts and the London NHS Trust. Clare is particularly interested in understanding how finance professionals can support the delivery of excellent patient care and outcomes.

Jo Thomas, Director of Nursing and Quality

Jo Thomas was appointed in June 2015 having previously held the post in an interim capacity since February 2015. Before joining QVH, Jo held chief nurse positions in both commissioning and acute provider organisations. Jo trained at Brighton University Hospitals NHS Trust and has 32 years of nursing experience in elective, specialist and emergency care, with a specialist interest and an MSc in women's health. She has senior management experience of leading and managing specialist services as well as extensive experience of operational delivery and the redesign of health care services.

John Thornton, Non-Executive Director

John has almost 30 years' experience as a senior executive in the financial services industry. He currently works as an ombudsman for the Financial Ombudsman Service and is involved in a range of business and community activities as a consultant, non-executive director and mentor. At QVH John chairs the finance and performance committee of the board of directors.

Richard Tyler, Chief Executive

Richard Tyler was chief executive at QVH from July 2013 until November 2016. He joined with over 20 years of experience gained in a variety of posts across the NHS. Previously, Richard had been chief executive at Hounslow and Richmond Community Healthcare NHS Trust and had held roles in operational management, business and performance management and strategic planning within acute trusts, primary care trusts and at strategic health authority level. He was succeeded by Steve Jenkin (see previous page).