Queen Victoria Hospital
NHS Foundation Trust

Quality Accounts
2013/14

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Part 1: Statement on quality

Chief executive's statement

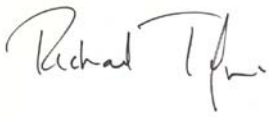
At Queen Victoria Hospital NHS Foundation Trust (QVH) we pride ourselves on the quality of care that we provide for our patients.

Patient surveys continue to give us ratings for quality that are among the highest in the country. Results from the latest national NHS inpatient survey demonstrate that we continue to be rated as one of the best hospitals in the country. For the second year in a row, we achieved the highest scores of any trust in England for the quality of our nursing care and the quality of support available on leaving hospital.

Similarly, the latest national NHS staff survey indicates that we continue to score well for staff recommending their trust as a place to work or receive treatment and for high levels of job satisfaction. Areas where we continued to score particularly well include the communication between managers and staff, staff feeling able to contribute towards improvements at work and staff motivation at work.

Whilst we have performed well we believe in continuous improvement. Therefore, these quality accounts both summarise the performance of the hospital across a range of issues in 2013/14 and set out our key priorities for 2014/15 which we believe will further improve our patients' care and hospital experience.

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



Richard Tyler
Chief Executive

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

Performance against 2013/14 priorities

Priorities for 2013/14 were influenced by information from national and local reports and audit findings along with the views of the trust's governors, the programme board (which includes representation from Crawley and Horsham & Mid Sussex Clinical Commissioning Groups), our lead clinical commissioning group, patient feedback and staff from across the organisation.

Four priorities were identified for 2013/14, covering patients' experience, the effectiveness of their medical care, and patient safety. After reviewing our achievements at the end of 2012/13 we identified that two priorities from that year would continue to benefit from additional focused activity to embed them into the routine work of the trust. These priorities were therefore carried over into 2013/14 and were:

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

Priority 1

We aim to improve the outpatient experience of all patients

Our aim:
Our objective was to commence measuring the patient experience in line with the NHS friends and family test question and to collect information on the time patients waited for their outpatient appointment. A number of activities were planned to support improving the overall experience for outpatients in 2013/14. We identified both the hand and corneoplastics clinics as areas to focus on as these clinics have a history of running late.

Our rationale:
This priority was selected for continuation in 2013/14 because we had identified that patient experience could be variable at times and the national outpatient surveys, supplemented by our own patient surveys, had highlighted that addressing a number of areas identified as requiring improvement could significantly improve the experience of our patients.

We achieved:
Over the year we delivered the activities we set out for the year and, overall, we are pleased with the progress made on improving the experience of outpatients. In the corneoplastic

clinic 80% of patients have had a 30% reduction in their waiting time. In the hand clinics we are now seeing 100 patients per month through clinics led by experienced hand therapists. This has allowed 50 new patients per month to be seen. Much of the activity has now become embedded practice and staff are continually looking to streamline activities. We introduced the friends and family test questionnaires within these services and the results showed that patients were satisfied with the service. Patient experience is a key strategic objective and work to continue making improvements will remain a priority. During 2014/15 this work will be overseen by the patient experience group, chaired by the director of nursing.

We made the following progress against the activities we planned during 2013/14:

- **Undertake a detailed assessment of demand and capacity leading to possible changes to the time allocated to clinic appointments.**
  Detailed demand and capacity work in the specialties of corneoplastics and hands has been undertaken, leading to clinic template changes and how patients are managed through X-ray for hand clinics to reduce the time patients wait for their appointment.
- **Review clinics which experience regular delays to explore how the clinic is managed and identify areas for improvement.**
  Process mapping of the patient flow in corneoplastics and hand clinics continues to further refine the flows through clinics to reduce waiting times and overrunning clinics.
- **Introduction of a daily named nurse in charge of the outpatient department.**
  We introduced a daily named nurse in charge of the outpatient clinics in all areas which. This is clearly visible for all patients, offering them the name of a senior member of staff they can request to speak with if they have any comments or concerns.
- **Commence nurse and therapy led clinics.**
  We introduced therapist-led hand clinics three times a week. This has released capacity in consultant clinics enabling us to see more patients overall and thereby reduce waiting times.
- **Introduce an alert system to address the issues in clinics that are delayed.**
  We introduced a clear escalation process within each outpatient department when clinics encounter delays to reduce the number of overrunning sessions. We undertook regular audits of start and finish times and investigated the reasons for any delays in order to identify trends to be addressed during 2014/15.
- **Introduction of a mechanism to ensure that clinic utilisation is maximised, in the same way as we do for our operating theatres (i.e. three weeks ahead).**
  The procurement of an additional module to our 'Patient Centre' software to allow smarter outpatient scheduling, has had to be dropped due to escalating costs. Alternative solutions are now being explored including extending our system for smart scheduling in theatres.
- **Extend the use of the self-check-in and patient calling system.**
  Our self-check-in and patient calling system roll-out was completed and 60% of patients check in via the kiosks each week. We are now planning to extend the use of the self-check-in and patient calling system to achieve a paper-light clinic. A pilot of electronic clinic outcome and waiting list forms will take place during the early part of 2014/15.
- **Introduce the NHS friends and family test.**
  We introduced the NHS friends and family test into our outpatient areas. Initially the information was collected as a single score. We have since looked to break the scores down by specific outpatient departments. Overall our NHS friends and family test results show a high level of satisfaction with the services we provide.

Priority 2

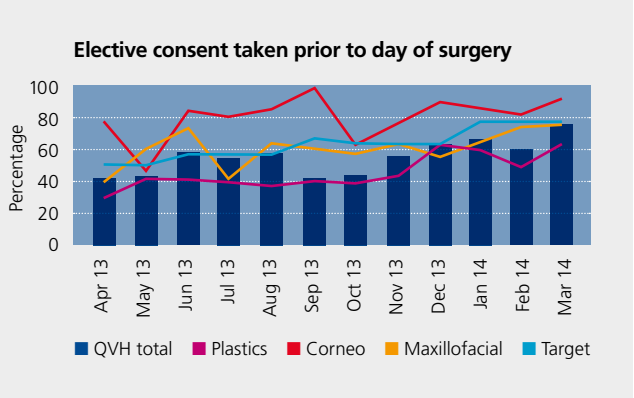
We aim to take patient consent for elective surgery prior to the day of surgery at QVH

Our aim:
Our aim was that during 2013/14, 75% of patients undergoing elective surgery at QVH would have their consent completed prior to their day of surgery. This was a continuation of a 2012/13 priority where we had achieved 48% against our target of 50%.

Our rationale:
This is an important priority for us because it can significantly improve the quality of care that our patients experience. Before patients can give informed consent to treatment, they need comprehensible information about their condition and about possible treatments and investigations, including the associated risks and benefits (which include the risks/benefits of doing nothing). They also need time in which to consider this information, and possibly discuss it with members of their family.

We achieved:
Progress by the end of 2013/14 fell just short of our target of 75%, reaching an aggregate figure of 72% by the end of the year. The pending shortfall was noted well before the end of the year and a concerted effort made to identify the reasons and push for greater compliance. The work that came out of this showed us that there is widespread medical support for this target, but that it remains hampered by process issues. These issues range from the hard to resolve, such as the availability of time, to more simple issues such as the routine availability of QVH consent forms within the patient's notes at the clinic.

The table below summarises our progress against the target overall and by specialty during 2013/14:



We are pleased with the progress made by our specialty teams over the year. The corneoplastics team has consistently maintained scores on or above the quarterly target with the plastic surgery team making significant progress during the second half of the year.

To build on the progress made this year, the medical director intends to keep promoting the target with his colleagues. We will continue to collect, present and challenge on the data and will provide the annual score within our clinical effectiveness measures next year but we will not continue this as a quality account priority for the coming year, in view of the substantial progress made over the past two years.

Priority 3

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

Our aim:
We identified submission of information to the Cancer Outcomes and Services Dataset (COSD) as a priority for 2013/14 because this was a new requirement introduced in January 2013. The dataset was the new national standard for reporting cancer outcomes for specific tumour sites in the NHS in England. The COSD required a significant number of items of information to be submitted electronically to the cancer registry on a monthly basis. The initial phase concentrated on items within the core and the relevant site-specific datasets which are mandatory for all cases diagnosed from 1 January 2013. This was followed by two further phases culminating in a complete dataset being regularly submitted every month by January 2015.

Our rationale:
This priority was identified as we consider the ability to provide outcome data as a priority at QVH and the ability to be able to provide timely data as requested to the COSD was recognised as important to achieve.

We achieved:
For 2013/14 we submitted the majority of the data on time in the correct format within one day of the deadline. There was only one occasion where the pathology data was submitted later than this. As processes have become embedded, and information is being consistently provided to the Thames Cancer Registry, we will not be continuing this as a priority in 2014/15.

The table below summarises our progress against the priority during 2013/14:

COSD conformance measures

	MDT File received by deadline	Pathology data received by deadline	PAS data file received by data	File received was COSD compliant format
Jan 13	N/A	N/A	N/A	
Feb 13	N/A	N/A	N/A	
Mar 13				
Apr 13				
May 13				
Jun 13				
Jul 13				
Aug 13				
Sep 13				
Oct 13				
Nov 13				
Dec 13				
Jan 14				
Feb 14				
Mar 14				

Compliant / on time
Non compliant / 1 day late
Non compliant / 2 or more days late

In the course of implementation, the Thames Cancer Registry had indicated they would provide quarterly updates regarding the data completeness for each trust. We had planned to use this to monitor our progress and to improve our data collection processes as required. However the central team was so overwhelmed with the amount of data being submitted to them that the only feedback we have received so far focuses on the timeliness and format of the data submitted.

Despite the lack of feedback from the national registry, the cancer team, along with key clinicians, has progressed to ensure that data required is being collected and streamlined to become as automated as possible.

Some data fields are still proving to be more difficult to collect and the team is currently working with the relevant departments to overcome these challenges during 2014.

Priority 4

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

Our aim:
During the year to we aimed to:

- review what information on consultants' results and outcomes in respect of patient safety, effectiveness of care and patient experience we would like to be able to provide to the public and commissioners
- identify the information systems available or invest in those required to support collection of the information
- request a review by the auditors.

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

We achieved:
We identified what information was available and collated this into a single format. This was regularly shared with the consultants over the year. The sharing of the information has provided some useful feedback and we have adapted the database over the last four months of the year. No audit review was formally undertaken as information was taken from sources already scrutinised for the quality account.

National progress on outcome measures has been slow and we have decided to proceed with our own measures, adopting national measures if and when they apply to us.

Information on progress has been regularly provided to the clinical outcomes group, the quality and risk committee, the management team, clinical cabinet and the board of directors.

In developing the current system we are conscious that the format is labour intensive and remains subject to errors if not subject to repeated manual checking due to the amalgamation of many datasets. We are therefore planning to employ a new IT resource in 2014/15 to improve our systems and processes.

During 2013/14 the board set up a sub-committee, the Board Outcomes Group, to oversee the development and implementation of consultant outcomes across the trust. The outcomes group has defined how the project will develop over the next year. A project manager will coordinate this work and we have received a great deal of support from our clinical teams to shape the outcome measures that will be reported on in the year ahead.

We will be publishing both clinical and patient reported outcome measures by consultant or team as far as possible on our website in 2014/15. We have opted to retain the provision of clinical outcomes information as a priority for 2014/15.

Priorities for 2014/15

Priorities for 2014/15 have been influenced by our progress on our 2013/14 priorities, the trust's governors, our lead clinical commissioning group and staff from across the organisation through their contributions to QVH 2020, our long-term strategic plan.

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

Four priorities were identified, covering patient experience, the effectiveness of medical care, and patient safety. Having monitored last year's objectives, we have determined that only the work associated with outcome measures will remain within the quality account for next year; all other priorities will continue as streams of work that will be monitored by the executive team during the coming year.

The four priorities proposed for QVH for 2014/15 are:

Priority 1

Provision of clinical outcome measures

At QVH we aim to deliver continuous improvements in the healthcare we provide and a key aspect of this is how we demonstrate those improvements to the public and patients. Quality assurance of healthcare demands that we critically examine and openly publish the effectiveness of procedures from the perspective of both patient and doctor. This enables us to continually improve the service we provide and ensure that no matter who delivers the care, patients and commissioners of services can be assured all patients receive demonstrably high quality care.

Clinical outcomes can be measured by activity information such as hospital re-admission rates or by other scales of improvement such as visual measurements or degree of joint movement. Clinical outcomes are discussed with patients along with the expected improvement to their quality of life that results from the care or treatment planned. Outcome measures can also be reported by patients and their families. Measures of treatment outcomes from the patient's perspective are called patient-reported outcome measures (PROMs). PROMs are an important part of outcome measurement because they provide a patient-led assessment of health and health-related quality of life. We have provided some in our quality account for the last three years.

For 2014/15 we plan to publish outcome measures at consultant or team level as appropriate. They will be made up of both PROMs and clinical outcome measures as decided in consultation with clinicians and patient focus groups. Data collection for most is in progress now and will be validated and uploaded over the year, beginning with orthognathic PROMs in May 2014.

We will publish a total of six outcome measures during the year. They will appear on the trust website and will be updated in accordance with the frequency of data collection.

Progress will be managed by the board sub-committee for clinical outcomes that includes both executive and non-executive directors. Quarterly updates will be provided to the board outcomes group, the quality and risk committee and the board throughout the year.

Priority 2

Scheduling of elective surgery

Having advance notice of their proposed surgery date is important to patients as it allows them to plan their personal arrangements accordingly. The national guidance on managing waiting lists states that all patients having planned surgery should ideally be offered a date for surgery that provides at least three weeks' notice. This does not apply to cancer patients for whom organisations are required to meet shorter timescales. At QVH we also have restrictions on our ability to give this much notice for some of our more complex patients where we have to plan their surgery dates around the availability of donor tissue required for surgery. This priority will support our 2014/15 Commissioning for Quality and Innovation (CQUIN) measure on reducing the number of offered surgery dates to patients that are subsequently changed.

For 2014/15, we plan to offer 80% of elective surgical patients with dates that allow at least three weeks' notice by the end of March 2015.

We would exclude cancer patients and patients requiring donor tissue from this target as these cases are planned to meet their individual needs. Delivery of this priority will enhance our patients' experience as they will have earlier notice/confirmation of their surgery date.

Our plan is to establish a baseline in Quarter 1 following the introduction of an upgrade to our patient administration system (PAS), with an aim that the percentage of patients booked with at least three weeks' notice increases in a phased manner during Quarters 2 and 3 in order to reach 80% by the end of 2014/15.

We will report on the percentage scheduled with three weeks' notice and we will report on the number of elective surgical cases cancelled and rebooked before admission for the convenience of QVH (i.e. non-clinical hospital cancellations rather than at the request of the patient or for clinical reasons).

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

Priority 3

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

Many patients visit QVH for their outpatient appointment and then have to return to us for minor surgery at a later date. Increasing the number of patients that are seen and treated for minor surgical interventions on the same day as their outpatient appointment would improve the their experience as it reduces the number of visits they are required to make to hospital and speed up their overall care.

In addition to the direct benefits for patients, changing our ways of working to see more patients on the same day will reduce the administrative time and resource previously required to book patients for multiple visits and type clinic letters. This means that staff will be able to focus more time on managing more complex patients through their pathway of care.

Initially, our aim is to increase the number of elective patients seen and treated on the same day by at least 50%.

Information will be provided monthly on the number of patients with skin lesions that we are treating each month on the day of their appointment as well as the overall length of time from referral to treatment and number of visits per episode. This information will be provided to the management team and included within the trust board papers.

Priority 4

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

The report by Sir Robert Francis on the care provided at Mid Staffordshire Hospital recommended that organisations should review the staffing they provide to deliver care at ward level. This was further supported by the document How to ensure the right people, with the right skills, are in the right place at the right time published by the National Quality Board and Hard Truths – The Journey to Putting Patients First (Volume Two of the Government Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry).

At QVH we have been reviewing staffing establishment and skill mix on our wards on a quarterly basis. We would like to make information about our staffing levels - against patient numbers, and their acuity and dependency – more visible and readily available to the public and the board of directors in a form that is clear and simple and is able to provide assurance.

We therefore aim to introduce an additional module to our electronic rostering system by the end of June 2014. Following implementation and training we anticipate that by September we will be able to provide real-time visibility of staffing levels across wards in relation to patient numbers and acuity. This will enable us to redeploy or enhance staffing in real-time and support the delivery of safe care to patients.

Progress on our achievements will be included within the safe staffing reports that will be being provided to the board of directors from May 2014.

Statements of assurance from the trust board

Review of services

During 2013/14 QVH provided burns care, general plastic surgery, head and neck surgery, maxillofacial surgery and corneoplastic surgery and community and rehabilitation services. QVH has reviewed all the data available to it on the quality of care in all of these NHS services.

The income generated by the relevant health services reviewed in 2013/14 represents 100% of the total income generated from the provision of relevant health services by QVH for 2013/14.

Review of quality of care

QVH has a governance structure in place which ensures that, through responsible committee groups and specialty directorate reviews, the executive team are able to assure themselves regularly on the quality of services provided to patients. At these meetings, the safety of care is reviewed through reports on incidents, infection control and identified risks. Where there are concerns or further assurance is felt to be required, action plans are put in place and reviewed at monthly operational meetings of the directorates or meetings involving the senior managers. Clinical effectiveness is reviewed through reports on cancelled operations, clinical indicators, clinical outcome measures, waiting times for surgery and patient complaints. Patient experience is reviewed through complaints and feedback questionnaires and is further supported by the national inpatient and cancer surveys. During 2013/14 the NHS friends and family test has been introduced nationally for hospital inpatients. At QVH we have rolled this out further to include our minor injuries unit and many of our outpatient clinics and our day surgery unit.

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

Where a significant incident or concern occurs or is identified by either the executive team or a directorate they will immediately commence an investigation and actions will be documented and regularly reviewed. Any significant incidents are reported through to the trust board and actions are followed up and monitored through the quality and risk committee.

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

Participation in clinical audits

During 2013/14, five national clinical audits and three national confidential enquiries covered relevant health services that QVH provides.

During 2013/14, QVH fully participated in 50% of the specified national clinical audits, partially participated in one additional audit, and fully participated in 100% of the national clinical audits and national confidential enquiries which it was eligible to take part in.

The national clinical audits and national confidential enquiries that QVH was eligible to participate in during 2013/14 are as follows:

National clinical audits	Participation
Head and neck oncology (DAHNO)	✓
Rheumatoid and Early Inflammatory Arthritis	✓
Patient Information and Consent (National Comparative Audit of Blood Transfusion)	Partial
National Cardiac Arrest Audit (NCAA)	✗
Adult critical care (ICNARC CMP)	✗

National confidential enquiries	Participation
Subarachnoid haemorrhage (NCEPOD)	✓
Alcohol related liver disease (NCEPOD)	✓
Tracheostomy Care (NCEPOD)	✓

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

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

We were ineligible to submit cases to the Patient Information and Consent (National Comparative Audit of Blood Transfusion), but completed and returned an organisational questionnaire. We will amend local transfusion and consent policies as appropriate in line with national recommendations arising from this study.

Three other national studies monitor mortalities from a range of causes. These are the Maternal, Infant and Perinatal Programme (MBRRACE-UK), the Child Health Programme (CHR-UK), and Suicide and Homicide for People with Mental Illness (NCISH). We are aware of these studies and we routinely review all of our small number of in-hospital deaths with a view to participation if appropriate. To date we have not had any relevant cases to report.

An additional three studies collect data from emergency departments for cases which may be relevant at QVH – the National Audit of Seizure Management, the Paracetamol Overdose (Care Provided in Emergency Departments) study and the Moderate or Severe Asthma in Children (Care Provided in Emergency Departments) study. However, for each of these studies, the numbers of relevant cases attending the minor injuries unit at QVH would not meet the minimum required to participate.

The national clinical audits and national confidential enquiries that QVH participated in, and for which data collection was completed during 2013/14, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the term of that audit or enquiry.

National audits / confidential enquiries	% cases submitted
Head and neck cancer (DAHNO)	100% relevant cases between November 2012 and October 2013
Tracheostomy Care (NCEPOD)	100% relevant cases
Subarachnoid haemorrhage (NCEPOD)	No relevant cases, but organisational data submitted
Alcohol related liver disease (NCEPOD)	No relevant cases, but organisational data submitted

Other national audits we have participated in during 2013/14 include:

- National NHS Inpatient Survey
- National Cancer Patient Experience Survey
- National Safety Thermometer
- International Burn Injury Database (IBID), incorporating the UK National Burn Injury Database (NBID)
- Foundation Trust Benchmarking 2013: Operating Theatres
- NAP5: National Anaesthetic Audit – accidental awareness during general anaesthesia in the UK
- Implementing the NICE public health guidance for the workplace organisational audit.

The reports of fifteen national clinical audits were reviewed by the provider in 2013/14 and QVH intends to take the following actions to improve the quality of healthcare provided:

- Coordinate a response to a number of national patient and staff surveys via the trust's patient experience group and Macmillan team, and to monitor actions taken
- Use a nationally-provided action plan pro-forma to improve the quality of local head and neck cancer services
- Continue progress towards implementation of a single, flexible and robust database for collection of head and neck data
- Review national guidelines for the pre-assessment of patients who may be consuming excessive alcohol and ensure that local guidelines are in line with national guidelines where appropriate
- Provide training addressing the importance of the accurate labelling of clinical samples, and follow up specific examples of mislabelling with the individuals involved
- Implement a blood transfusion flow chart covering the transfusion pathway at QVH
- Continue to ensure the presentation of findings of relevant national audits and confidential enquiries to a trust-wide audience to increase awareness.

The reports of 156 local clinical audits were reviewed by the provider in 2013/14 and QVH intends to take the following actions to improve the quality of healthcare provided:

- Continue to identify and review post-operative venous thromboembolism (VTE) cases from multiple sources, and carry out root cause analysis as appropriate
- Implement VTE prophylaxis at home, following 'free flap' surgery for breast reconstruction, as appropriate
- Highlight documentation issues during junior doctor induction training and feed-back learning from on-going local documentation audits to a trust-wide audience
- Continue to carry out monthly 'compliance in practice' assessments, launched during 2013/2014 in clinical areas, in order to identify areas of non-compliance against Care Quality Commission requirements, and to implement remedial actions in a timely fashion as required
- Add the audit Malnutrition Universal Screening Tool (MUST) risk assessment data to the 'safety thermometer' data collection tool and include the results in the board safety metrics for 2014/15
- Seek additional feedback from local coroners on the small number of mortalities occurring at QVH (and post-discharge, following surgery here) and to disseminate learning to a trust-wide audience
- Continue progress made on the production of a number of publishable specialty-specific consultant-level outcomes during the forthcoming year, integrating local learning from new methods of collecting patient reported outcome measures.
- Implement the blood transfusion decision tree within the burns unit, and carry out re-audit
- Implement new methods of data collection within various departments in order to improve our ability to monitor outcomes and to carry out additional data analysis.

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by QVH in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 424.

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

QVH was involved in conducting 41 clinical research studies in 2013/14, involving clinical staff in four medical specialties as well as professions allied to medicine.

Use of the Commissioning for Quality and Innovation payment framework

A proportion of QVH income in 2013/14 was conditional on achieving quality improvement and innovation goals agreed between QVH and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further detail of the agreed goals for 2013/14 and for the following 12 month period are available online at www.qvh.nhs.uk/assets/publication/CQUIN2014.pdf .

The monetary value attached to achieving CQUINs for 2013/14 was £1,290,144. Activity to achieve CQUINs was undertaken and regularly reported on. A total £1,175,664 associated payment was made for CQUINS in 2012/13. This was a 100% achievement of our CQUINs for 2012/13.

Care Quality Commission registration and periodic and special reviews

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

The CQC has not taken enforcement action against QVH during 2013/14.

QVH has participated in a routine inspection by the CQC relating to the following areas during 2013/14:

- a short notice announced inspection of compliance with the ionising radiation (medical exposure) regulations (IR(ME)R) of the radiology service at QVH on 18 February 2014.

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

- Produce a document to show the procedures that are in place for evidence of compliance, for example how new staff obtain information
- Provide a flow chart showing the progress of radiation through the hospital
- Introduce into every x-ray room a full exposure chart for children of various ages for the most common examinations
- Provide a full protocol for children for cone beam and fluoroscopy cases
- Deliver a plan to bring in additional cover to oversee any dose reference work, advise on protocols and oversee any other IR(ME)R requirements as required.

Following an inspection undertaken in February 2013, the CQC performed an unannounced follow up visit in September 2013. At this it was noted that the trust was now compliant in respect of Outcome 21 (that people's personal records, including medical records, should be accurate and kept safe and confidential).

QVH had made the following progress by 31 March 2014 in respect of Outcome 21:

- Delivery of a record-keeping standards education session for staff across all clinical areas
- Completion of quarterly patient record audits resulting in action plans - with ownership - where non-compliance is noted
- Introduction of 'compliance in practice' audits of all areas, that commenced with those identified within the CQC report
- Updating, publishing and communicating the policy and procedures for the radiology department
- Improving the collection and accessibility Radiation Protection Supervisors (RPS) records and operators' qualifications
- Introducing processes to allow more comprehensive documentation of care and to support an integrated patient health record. Action here is noted to be limited as the trust is working towards developing an electronic health record.

Data quality

QVH submitted records during 2013/14 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

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

- 99.6% for admitted patient care
- 99.6% for outpatient care
- 98.3% for accident and emergency care.

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

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

QVH's overall information governance assessment report overall score for 2013/14 was 82% and was graded satisfactory.

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

Part 3: Review of quality performance 2012/13

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

Patient safety

At QVH we strive to deliver high quality care to patients. Patient safety and preventing harm to patients are our priorities. Patient safety is included within our key strategic objective of 'outstanding patient experience' where patients are at the heart of safe, compassionate and competent care provided by well-led teams in an environment that meets the needs of patients and their families. This approach to safe care is supported by our risk strategy and our approach of looking consistently at the care we deliver with the aim of reducing harm to patients. At QVH we see continuous development of staff as key to delivering safe care. By improving clinical leadership, communication and learning we aim to create an environment of trust between patients and staff that ensures that safe, high quality, effective care is delivered to all our patients consistently.

We continue to investigate all incidents, including all deaths and complications. These are investigated and discussed at regular clinical directorate meetings and where there is significant learning this is shared at bimonthly joint hospital clinical audit meetings at which there is representation from across the organisation including non-executive directors. Other learning points and actions are shared with relevant staff groups and dissemination occurs through the directorate team meetings, clinical policy and quality and risk committees, clinical cabinet, and the board of directors.

Within this year's safety metrics we are pleased to report that we have continued to improve our physiological monitoring of patients during their admission, our assessment of patients for their risk of venous thromboembolism (VTE) and our theatre lists commencing with a pre-list briefing.

An area we have identified where we could improve on the care we deliver is our assessment of nutrition. While we did complete a nutritional assessment of nearly all our patients, for 84% of them this did not occur within 24 hours of admission. To make sure we improve on this measure next year we will continue to collect information each month and will do this as a part of the national 'safety thermometer' data collection. The results will form part of the ward safety measures that will be included in reports on ward performance to the board of directors.

We take hospital acquired infection very seriously at QVH. This year, while we have had no cases of MRSA bacteraemia, we had one case of Clostridium difficile. This patient was someone who had a significant infection and required multiple antibiotics; this does put the patient at risk of Clostridium difficile but was a requirement to enable them to recover to full health. Actions taken to protect other patients from Clostridium difficile include audit and monitoring of antibiotic use and prompt action where a patient's condition gives cause for concern, including screening and isolation from other patients to proactively prevent the spread of infection.

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

Patient safety indicator and why we measure it	How the data is collected	Our target	Benchmark	2011/12	2012/13	2013/14
Clinical incidents reported per 1000 patient spells (spell = outpatient visit or inpatient stay)	Monthly analysis of Datix clinical incident reporting system	N/A	91 per 1000 specialist acute trusts NRLS benchmark (Oct 12 to Mar 13)	44 per 1000 patient spells	43 per 1000 patient spells	57 per 1000 patient spells G
Comment: We actively encourage staff to report all incidents that have, or have potential to have, an effect on patient safety. We operate an open reporting system to aid learning from incidents. An increase in the reporting of incidents is seen as positive involvement by staff in reporting actual or potential incidents that could harm patients. During 2014/15 we will continue to encourage incident reporting by all staff.						
***Number of clinical incidents reported that have caused patient harm (actual number)**	Monthly analysis of Datix clinical incident reporting system Rate of patient safety incidents reported	0	32% of all incidents reported (NRLS of specialist trusts (Apr to Sep 2012)	124 incidents causing harm 17% of all reported incidents 7 causing moderate harm; 0 causing major harm or death	118 incidents causing harm 16% of all reported incidents 3 causing moderate harm; 0 causing major harm or death	130 incidents causing harm 13% of all reported incidents 11 causing moderate harm; 0 causing major harm or death A
Comment: QVH considers that this data is as described for the following reasons: Although we would like to see a large number of clinical incidents reported to aid governance, we would like a low number of incidents that have caused patient harm. No incidents have resulted in significant harm or death and this is supported by a low number of serious incidents reported during 2013/14 (n=5), this is the same number as reported in 2013/14. Others were reported during the year and later downgraded on completion of an investigation. All incidents that have caused harm or had the potential to cause harm are thoroughly investigated and findings are reported to the quality and risk committee. The QVH has taken the following actions to improve this score and so the quality of its services by raising awareness through the mandatory training programme of the harm caused to patients from various incidents in order to reduce the percentage of incidents resulting in harm. The National patient safety agency (NPSA) describe harm as the following: • **Moderate harm -** Any unexpected or unintended incident which resulted in further treatment, possible surgical intervention, cancelling of treatment, or transfer to another area and which caused short term harm, to one or more persons. • **Severe harm (major)** - Any unexpected or unintended incident which caused permanent or long term harm, to one or more persons.						
Hand hygiene (washing or alcohol gel use)	Internal monthly audit of the five moments of hand hygiene	100%	N/A	97%	98%	99% G
Comment: Good hand hygiene is linked with a reduction in hospital-acquired infections. This measure has shown a consistent improvement over time. To ensure standards remain high, monthly audits are undertaken in all clinical areas and any staff member noted not to be complying is challenged and reminded why compliance is required.						
***VTE risk assessment (per cent of admissions)**	Health and Social Care Information Centre data	(95% national target) National average Feb 2014 96%	NHS funded acute care 94.2% (Q3 data 2012/13) Range over Q3 74.8%-100%	90%	92.3% NB: Last 2 years data collected against all patients admitted rather than a single day audit	100% G
Comment: Patients undergoing surgery can be at risk of VTE (venous thromboembolism). Those assessed at risk can have the correct precautions, including compression stockings and low molecular weight heparin. The 'safety thermometer' provides wards with a rate of harm-free care provided to patients, an aspect of which includes the assessment of patients for VTE risk on admission and after 24 hours following admission, and takes into account whether any prescribed medications were administered. This information has been collected throughout the year and we have been able to improve our rate of compliance over the year.						

Patient safety indicator and why we measure it	How the data is collected	Our target	Benchmark	2010/11 result	2011/12 result	2012/13 result
Nutritional assessment within 24 hours of admission	Three-monthly internal audit	>90%	N/A	86%	93%	94% A
Comment: Maintenance of nutrition is important for physical and psychological wellbeing. When illness or injury occurs, nutrition is an essential factor in promoting healing and reinforcing resistance to infection. During 2013/14 this has been monitored on a monthly basis, identifying that some patients had not had their assessment completed within the required time (24 hours). While many of our patients are fit and not at risk we recognise that we should be achieving a higher score. Therefore this measure is going to be included within our nationally required data collection for the 'safety thermometer'. This information is collected by senior nursing staff each month and results will be included in ward safety dashboards that are reported to the board of directors.						
Theatre lists starting with a surgical team safety briefing	Monthly internal audit	>90%	N/A	86%	93%	94% G
Comment: A whole-team safety briefing with surgical, anaesthetic and nursing staff before theatre lists begin improves communication, teamwork and patient safety in the operating theatre. We are pleased to see that during 2013/14 this process, which is there to improve safety, has become more embedded as routine practice. There will be a continued focus on this during 2014/15 with the aim of increasing compliance to >95%.						
Use of the WHO Safer Surgery checklist	Monthly internal audit	100%	Sign in	96%	99.2%	98%
			Time out	84.8%	99.2%	96%
			Sign out	62.9%	98.3%	82% A
Comment: The correct use of a checklist prior to anaesthesia and surgical incision reduces 'never events' such as wrong-site surgery. As with the surgical team safety briefing, this measure is there to improve patient safety. During 2013/14 we have had incidents that we know could have been prevented or identified earlier if we had a higher compliance with both the 'time out' and 'sign out' aspects of the WHO safer surgery checklist. For 2014/15, besides auditing the occurrence rate, we will also perform a qualitative audit that will document those that participated in the checklist process. This audit has been identified as a CQUIN measure for 2014/15.						
Development of pressure ulcer grade 2 or over (per 1000 spells)	Internal audit	0	0.84 / 1000 admissions (SEC Jan 12)	0.5/ 1000spells (total number = 8 cases)	0.2/1000 spells (total number = 3 cases)	0.5/ 1000 spells (total number = 8 cases) A
Comment: Pressure ulcers can cause serious pain and severe harm to patients and cost the NHS billions of pounds each year to treat. In the majority of cases they can be prevented if simple measures are followed. These figures are for hospital acquired injury and we are pleased to see that we achieved a reduction on the number of cases from previous years. This would indicate that staff are reviewing patients and taking relevant action to prevent harm occurring.						
Patient falls, including falls associated with harm (actual number)	Internal audit	<1 per 1000 spells	2.2 / 1000 admissions (SEC SHA Jan 12)	56 falls 3.4/1000 spells 20 causing harm 1.2/1000 spells	64 falls 3.9/1000 spells 26 causing harm 1.6/1000 spells	49 falls 2.9/1000 spells 16 causing harm 0.9/1000 spells G
Comment: Our falls assessment procedures were changed in 2012/13 and have continued to be used during 2013/14. These included processes for alerting all staff to patients at risk. Our incidents of harm have decreased and no falls resulted in major harm, with the majority causing minor harm such as a scratch or graze. In many cases a fall is due to the patient's wish to be more mobile.						
Number of reportable MRSA bacteraemia cases	Internal audit	1	N/A	2	2	0 G
Comment: MRSA in the blood may be a hospital acquired infection and is a particular risk in patients with burns. No cases were acquired during 2013/14. Where cases do occur each case is thoroughly investigated by root cause analysis and areas for improvement are identified.						

Patient safety indicator and why we measure it	How the data is collected	Our target	Benchmark	2011/12	2012/13	2013/14
***Number of reportable Clostridium difficile cases**	Health and Social Care Information Centre data	0	National average 2011/12 21.8/100,000 bed days Range 0-51.6/ 100,000 bed days	Total = 0 0/100,000 bed days	Total = 0 0/100,000 bed days	Total = 1 0/100,000 bed days G
Comment: QVH considers that this data is as described for the following reasons: Clostridium difficile may be a hospital-acquired infection. Each case is thoroughly investigated by root cause analysis. One case does not mean we breach our national target as a *de minimis* of 12 is set for Clostridium difficile QVH took the following actions to improve this score and so the quality of its services by reviewing our antibiotic policy to ensure we maintain a low tolerance towards patients acquiring Clostridium difficile infections. We will continue to closely monitor patients and proactively screen and manage patients who give any cause for concern.						
Patients receiving all correct physiological monitoring during admission	Internal fortnightly audit of 10 patient records	>95%	N/A	80% (2011)	96%	97% G
Comment: Monitoring of pulse, blood pressure, respiratory rate, temperature, pain and sedation is important to detect and prevent physiological deterioration of patients. Our improving score shows that real-time monitoring and the ability to provide prompt feedback to staff has continued to improve patient assessment.						
Percentage of staff witnessing harmful errors, incidents or near misses in the last month	National staff survey	N/A	30% national average acute specialist trusts 2013	30%	31%	27% G
Comment: Ideally no errors, incidents or near misses should occur. Where these are known about staff will report them for investigation.						
Percentage staff uptake of seasonal influenza vaccine	Internal audit	>60%	National rate 46% 2012/13	59%	52.3%t	55% A
Comment: Frontline staff uptake of influenza vaccine is crucial in ensuring that the organisation is able to maintain services during an influenza outbreak and supports delivery of our emergency and business continuity plans. It was disappointing that our staff uptake rate did not exceed 60% especially as there was an increased focus by the NHS on the importance of vaccination. We will continue to have a proactive approach, providing roving clinics as a part of the vaccination programme and other open sessions for all staff.						

Clinical effectiveness

As a specialist hospital, we provide a specific range of surgical treatments to a broad patient population. As a result of this, many of the national measures and audits of clinical effectiveness will not apply to us, and tend to focus on the more common conditions that patients attend hospital for such as diabetes and common cancers. QVH is collecting measures of its own specific treatment outcomes so that clinicians, patients and other stakeholders can be assured the treatments all our consultants and medical staff offer are of the highest quality. The complexity of data collection, analysis and presentation to a wide audience makes this a formidable task and after considerable work by key medical staff, we will begin to publish data in May 2014 and aim to increase the amount available throughout the year.

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

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

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

All specialties						
Clinical effectiveness indicator and why we measure it	**How we measure it**	**Target**	**Benchmark**	**2011/12**	**2012/13**	**2013/14**
We aim to take patient consent for elective surgery prior to the day of surgery at QVH	Monthly internal audit	>75%	N/A	N/A	48%	72% A
Comment: Good progress has been made this year and while we did not quite achieve the target set of 75% we will continue to measure and ensure that this measure is seen as a priority and a mark of good practice.						
In-hospital surgical mortality	Continuous monitoring of PAS data	N/A	N/A	2011 0.015%	2012 0.007%	2013 0.007% A
Comment: Because of our specialist work it is not possible to present a comparable hospital standardised mortality ratio. We do, however, monitor death rates in burns care and surgery. The death rate presented here represents only one surgical death this year. One death can make a significant difference to the trust's mortality rate. All deaths at QVH are reviewed within specialties and in a multidisciplinary forum.						
***Percentage of patients aged 0-14 readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period**	Health and Social Care Information Centre data	N/A	England 2011/12 10.01 (range 0.00 to 14.94) Acute specialist trust data not grouped this year	2010/11 8.71	2011/12 8.11	2012/13 Not available from HSCIC until December 2014 A
Comment: Data for 2012/13 awaiting publication. QVH considers that this data is as described for the following reasons: some of our surgery is trauma related and we would expect a certain number of re-admissions. For 2011/12 our score lies within the national average. QVH intends to take the following actions to improve this score, and so the quality of its services by continuing to provide discharge information to patients, and raising awareness amongst clinicians through; continued audit and feedback to a trust-wide audience and; providing information on individual re-admissions to clinical specialty groups on a monthly basis for their further analysis and review.						
***Percentage of patients aged 15 and over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period**	Health and Social Care Information Centre data	N/A	England 11/12 11.45 (range 0.00 to 53.31) Acute specialist trust data not grouped	2010/11 16 and over 9.71	2011/12 16 and over 9.64	2012/13 Not available from HSCIC until December 2014 A
Comment: Data for 2012/13 awaiting publication. QVH considers that this data is as described for the following reasons: some of our surgery is complex and/or trauma related and we would expect a certain number of re-admissions. Information for 2011/12 shows that we performed significantly better than the national average at the 95% level but not at the 99.8% level. QVH intends to take the following actions to improve this score, and so the quality of its services by continuing to provide discharge information to patients, and will raise awareness amongst clinicians through; continued audit and feedback to a trust-wide audience; and providing information on individual readmissions to clinical specialty groups on a monthly basis for their further analysis and review.						
Unexpected return to theatre within 7 days	Continuous monitoring of PAS data (change of methodology Apr 2010)	N/A	N/A	0.84%	1.02%	1.05% A
Comment: A patient may have to unexpectedly return to theatre because of post-operative bleeding, infection or other complication. We have maintained a similar rate to 2012/13. This rate is due to the number of complex surgical procedures requiring free tissue transfer. It is well recognised that in order to get a high success rate in the long term a small number of patients will require a return to theatre in the first seven days to re-inspect the delicate anastomosis (join) between blood vessels that keeps the free tissue transfer alive.						

All specialties						
Clinical effectiveness indicator and why we measure it	**How we measure it**	**Target**	**Benchmark**	**2011/12**	**2012/13**	**2013/14**
Unexpected readmission to QVH within 28 days following discharge	Continuous monitoring of PAS data (change of methodology Sep 2010)	<1.5%	N/A	1.08%	1.45% (2012) 1.48% (2012/13)	1.37% G
Comment: A readmission may be due to wound complications or other complications from surgery. Due to the volume of complex surgery we carry out we are not surprised that this rate has remained similar to last year. We have improved our discharge information to patients, as early recognition of symptoms and good patient self-care on discharge can influence whether a readmission is required.						
Unplanned transfer out of QVH for additional care	Internal audit	<1.5%	N/A	0.28%	0.27%	0.33% G
Comment: We are supported by surrounding trusts in the provision of specialist services - such as respiratory medicine and cardiology - which we are unable to provide. We monitor our rates of unplanned transfer to surrounding trusts for these services. There has been a marginal increase in the rate of unplanned transfers but this reflects an increase in the amount of complex surgery we are undertaking and the associated increased risk of unplanned transfers. All clinical specialty groups are provided with the details of individual cases for analysis and review.						

Burns care

In 2013 the burns centre accepted 886 adult (over 16 years of age) burns referrals, a slight decrease from 949 in 2012. Over the year the unit was able to admit every clinically appropriate new referral from our catchment area.

Of these, 185 patients required inpatient care and 35 needed treatment in our intensive care unit (ICU). Of the referrals, 35 patients were accepted for specialist surgical reconstruction required because of significant skin loss from causes other than burns, e.g. necrotising fasciitis. Five patients received specialist rehabilitation care in our dedicated 'burns rehabilitation flats' facility.

In 2013, the QVH burns centre had one burns patient who died whist an inpatient. This patient had been admitted for comfort care (palliative care) as she had injuries that she would not be able to survive. This equates to a burns inpatient mortality rate of 0.7%, a decrease from 4.6% in 2012. One major burns patient died after a transfer out to a burns centre for haemofiltration. An additional patient who had been admitted for reconstructive surgery required due to necrotising fasciitis died post transfer out to another hospital for alternative specialist care.

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

QVH accepted 756 paediatric burns referrals during 2013, an increase from 678 in 2012. Of these, 78 required inpatient care on our paediatric ward.

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

Clinical effectiveness indicator and why we measure it	**How the data is collected**	**Target**	**Benchmark**	**2011/12**	**2012/13**	**2013/14**
Adult burn wounds healing within 21 days	Prospective database of all adult burns	100%	N/A	77%	73%	74%
Average time for adult burn would healing (median)		< 21 days	N/A	16 days	14 days	17 days
Paediatric (<16 years) burns wound healing within 21 days		100%	N/A	83%	79%	88%
Average time for paediatric burn wound healing (median)		< 21 days	N/A	13 days	16 days	16 days
Comment: Burns healing in less than 21 days are less likely to be associated with poor long-term scars. A shorter burn healing time may reflect better quality of care through dressings, surgery and prevention of infection. Some data on healing time could not be collected, particularly when patients do not attend their follow up clinics or are transferred for care elsewhere. The adult burns service experienced a 9% 'did not attend' (DNA) rate for follow up and an 11% 'care transferred' rate where patients were transferred to care closer to home. The absence of this data could mean several things. It could be assumed that patients who 'DNA' do not require further treatment and so healing times could be reduced. Patients transferred to other providers may be due to prolonged healing time or the development of chronic wounds which are most commonly treated in the patient's local area rather than a supra-regional service such as QVH.						

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2011/12	2012/13	2013/14
Average length of adult inpatient stay (bed days) per percentage burn for acute injury admissions	Prospective database of all adult burns	<65 years old - 1 day >65 years old - 2 days	N/A	1 day 2 days	1.5 days 2 days	1.6 days 3.6 days
Average length of paediatric inpatient stay (bed days) per percentage burn for acute injury admissions		<16 years - 2 days	N/A	Not audited	0.8 days	1.1 days

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

- Adult inpatients aged 17-65 years of age should require one-day stay per 1% burn
- Adult inpatients over 65 years should require a two-day stay per 1% burn
- Paediatric inpatients aged 0-16 years should require a two-day stay per 1% burn.

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

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

Breast surgery

QVH is the major regional centre for complex microvascular breast reconstruction, either at the same time as a mastectomy for breast cancer (immediate) or after all treatment has been completed (delayed). We sometimes do reconstructions after removing both breasts on the same day in ladies who have a genetic predisposition for breast cancer (BRACA gene). Our integrated team of consultants and specialist breast care nurses provide a wide range of reconstructive options and flexibility and also undertake reconstructive surgery for breast reduction and to correct breast asymmetry and congenital breast shape deformity.

Breast reconstruction after mastectomy using free tissue transfer – flap survival

The 'gold standard' for breast reconstruction after a mastectomy is a 'free flap' reconstruction using microvascular techniques to take tissue, usually from the abdomen, and use it to form a new breast. If the abdomen is insufficient, tissue can be used from the inner thigh or the bottom as a free flap for breast reconstruction. This technique has greater patient satisfaction and longevity but can carry greater risks than an implant or pedicled flap reconstruction. Therefore it is important that we monitor our success both in terms of clinical outcomes and, equally importantly, how the women feel throughout the reconstructive journey. The latter is called a patient reported outcome measure (PROM).

In 2013 the breast team performed a total of 188 flaps in 167 patients. This is a 5% increase on 2012. Of these, 178 flaps were from the abdomen and 10 from the thigh. Breast reconstruction was performed immediately after the mastectomy in 75 cases (39.9%). This is a significant increase from 2012 (26.3%) and is part of an increasing trend towards immediate reconstruction where possible. Of the 167 women operated on, 23 (13.8%) had both breasts reconstructed. This is the same as 2012.

Our total failure rate was two flaps out of 188 performed (1.06%). All flaps from the thigh survived (0% total failure) whilst two flaps from the abdomen did not (1.12% total failure). This is well below the national quoted rates of 2%.

New for 2014 has been the development of a five-point PROM form for patients to complete throughout their reconstructive journey. It is hoped that it will allow comparison from the preoperative period to the end of treatment. This will see if there is an improvement from the women's point of view. In addition it will allow PROM profiles between different types of reconstructions. Furthermore, PROM scores for individual consultants will be possible with the collection of this prospective information.

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2011/12	2012/13	2013/14
Breast reconstruction after mastectomy using free tissue transfer – flap survival	Continuous prospective electronic database	100%	95–98% (published literature) 98% BAPRAS 2009	99.2%	99.44%	98.94%

Comment: The 'gold standard' for breast reconstruction after a mastectomy is a 'free flap' reconstruction using microvascular techniques. The breast team's results continue to exceed the national average for free flap survival.

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

Hand surgery

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

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

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

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2011/12	2012/13	2013/14
Rupture rate following repair of flexor tendon injuries	On-going monthly audit between hand surgeons and hand therapists, with complication data collected via a trauma database	0%	9–13% (published literature)	3.5%	5%	2%

Comment: Hand surgery accounts for 80% of the trauma workload of the hospital, with flexor tendon repair the most common injury requiring surgery. In 2013 we carried out 283 primary repairs of flexor tendon injuries. Monitoring rates of rupture of the repaired tendon is one way of monitoring quality of surgery and post-operative therapy.

Skin cancer care and surgery

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

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2011/12	2012/13	2013/14
Complete excision rates in Basal Cell Carcinoma (BCC)	Audit of two months activity (286 BCC cases)	100%	88.9–95.3% (published literature)	90.7%	91.7%	92.5%

Comment: BCC is the most common cancer in Europe, Australia and the USA. Management usually involves surgical excision, photodynamic therapy (PDT), curettage, immuno-modulators, or a combination. Surgical excision is highly effective with a recurrence rate of 2%. Complete surgical excision is important to reduce recurrence rates. This may not be possible because of the size or position of the tumour or because the incomplete excision will only be evident with histological examination of the excised tissue. The high rate of complete excision for QVH is particularly pleasing as 40% of our referrals are from dermatologists who refer more complex cases. In 2013, 1,513 BCCs were removed at QVH.

Complete excision rates in malignant melanoma	Audit of two months activity (42 melanoma cases)	100%	75% NICE guidance	90%	95.6%	96.5%

Comment: Melanomas are excised with margins of healthy tissue around them, depending on the type, size and spread of tumour. These margins are set by national and local guidelines and each case is discussed in a multidisciplinary team (MDT). Total excision may not be possible because of the health of the patient or the size, position or spread of the tumour, and the MDT may recommend incomplete excision. In 2013, 326 melanomas were removed at QVH.

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

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

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

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2011/12	2012/13	2013/14
Facial nerve injury rates in condylar fracture (jaw fracture) repair	Trauma Card (continuous trauma and complications database)	0%	17%	0%	5.8%	0%
Comment: We monitor damage to the facial nerve during open fixation of mandibular fractures. We continue to have a zero permanent nerve injury rate. In 2013 we identified 12 cases that had the potential for injury to the facial nerve (mandibular condylar fractures treated with open reduction and internal fixation). There was no evidence of facial injury in any of the patients surveyed.						
Nerve injury rates in third molar (wisdom tooth) extraction and mandibular (jaw) fracture surgery	Telephone review of patients with 60% response rate from a sample of 100 consecutive cases	0% lip 0% tounge	5-10% (Temp) 2-8% (Temp)	5% (Temp) 9% (Temp)	4.7% (temp) 0.79% (> 6 months) 8.7% (Temp)	6.5% (temp) 0% (> 6 months) 8.2% (Temp)
	Temp = temporary >6 months = nerve injury taking more than 6 months to recover				1.2% (>6 months)	0% (>6/ months)
Comment: Wisdom tooth extraction is a common procedure. A recognised complication is inferior dental or lingual nerve injury, which may be temporary or permanent. In 2013 we treated 693 patients for extraction of the third molar tooth. The rates for 2011/12 and 2012/13 have been collected initially through telephone interview, rather than direct examination as in earlier years. For 2014 we plan to carry out a retrospective telephone interview at one, three and six months, with the aim of surveying 200 patients.						
Patient reported outcome measures (PROM) in Orthognathic surgery (correction of bony jaw abnormalities)	Prospective database of all orthognathic surgery patients	How do you rate the orthodontic service and care?		**2011** 80% excellent; 10% good; 10% average	**2012** 90% excellent; 10% good	**2013** 83% excellent; 17% good
		How do you rate the surgical service and care?		90% excellent; 10% good	92% excellent; 8% good	85% excellent; 15% good
		How satisfied are you with facial appearance?		70% very satisfied; 10% satisfied 20% neither satisfied or dissatisfied	74% very satisfied; 26% satisfied	71% very satisfied; 28% satisfied; 1% neither satisfied or dissatisfied
		How satisfied are you with dental appearance?		80% very satisfied; 10% neither satisfied or dissatisfied; 10% dissatisfied	85% very satisfied; 15% satisfied	72% very satisfied; 27% satisfied; 1% neither satisfied or dissatisfied
Comment: We undertake approximately 120 orthognathic surgical procedures per year. Successful orthognathic surgery demands good teamwork between the orthodontic team and the maxillofacial surgery team. Our results demonstrate a very high level of satisfaction with both teams as well as good satisfaction with the overall facial and dental result.						

Clinical effectiveness indicator and why we measure it	How the data is collected	Benchmark	2011/12	2012/13	2013/14
Peer Assessment Rating (PAR) index for orthodontic treatment	Continuous prospective data collection on all orthodontic patients	>70% = very high standard < 50% = poor standard	95%	95%	95%

Comment: The PAR (Peer Assessment Rating) index provides an objective measure to assess the improvement gained by orthodontic treatment. The higher the pre-treatment PAR score, the poorer the bite / occlusion. At QVH, data continues to be prospectively collected by independent third-party assessment of all our orthodontic patients following their treatment.

A graph produced from the results splits the data into three clearly defined categories: greatly improved, improved and worse/no different. With respect to interpreting the results, a mean PAR score improvement of greater than 70% represents a high standard of treatment.

For QVH, 95% of our patients were assessed in the first two categories with 50% in the 'greatly improved' category. These results are well in excess of national average figures and demonstrate very good outcomes for patients treated by the orthodontic department at QVH.

Patients whose outcomes do not improve as we would like are investigated by the team and a root cause analysis undertaken so we can identify causes and improve future care for others wherever possible. This investigation and review occurs on an annual basis.

Patient satisfaction in orthodontics

Questionnaires are given to every patient who has completed orthodontic treatment. The aim of this rolling prospective audit is to measure the level of patient satisfaction on completion of their treatment and at one year after completion of treatment. In 2013, 211 patients completed a satisfaction questionnaire. The majority (89%) were completely satisfied with the result of their treatment, and the reaming 11% were fairly satisfied.

Results showed that 96% of patients were happy with the appearance of their teeth after treatment, 72% reported improved self-confidence, and 92% would recommend a similar course of treatment to a friend. In addition, 96% of patients felt that they were given sufficient information regarding their proposed treatment with 99% of patients stating they were glad they undertook their course of treatment.

Corneoplastic and oculoplastic surgery

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

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

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2011/12	2012/13	2013/14
Percentage of patients achieving vision better than 6/12 after cataract surgery without other eye disease	Annual audit of 100 patients	100%	96% (UK EPR)	96%	100% with correction 90% unaided	100% with correction 90% unaided

Comment: There were 815 cases of phacoemulsification for cataracts recorded in 2013. Departmental audit shows that cases of post-operative eye infection are extremely rare and well below national average rates. We monitor the number of these patients who achieve significant improvement to the vision in that eye.

Anaesthetics

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

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2011/12	2012/13	2013/14
Clinical effectiveness indicator and why we measure it	Continuous prospective audit of all inpatient recovery room procedures	100%		79%	84%	88%

Comment: The anaesthetic recovery room exists to ensure that patients are fit to discharge to the ward following surgery. We monitor all interventions that are made in recovery, including medical review, intravenous analgesia, unexpected discharge to critical care and all complications such as hypothermia or airway difficulties. A supplementary local audit of 100 patients having upper limb surgery under regional anaesthesia showed that 94% of these patients rated their experience of anaesthesia as excellent or good, and 94% would be happy to have a similar procedure under regional anaesthesia.

Patient experience

QVH places great importance on ensuring our patients have an excellent experience and we continue to have exceptional patient satisfaction survey results.

The CQC has recently published the results of the 2013 national NHS inpatient survey. The survey was completed by 415 patients who had stayed at QVH for at least one night during June, July or August 2013. For the second year in a row, we achieved the highest overall score of any trust in England for the section of questions on the quality of nursing care and the support available on leaving hospital. Compared with the other 156 acute and specialist trusts in England, QVH scored better than average on 45 of the 68 questions and about the same as average on the remaining 23.

The trust continues to hold a patient experience group chaired by the director of nursing and quality. The group looks at all information relating to patient experience at the hospital and drives changes required based on the feedback received.

The trust also uses the NHS friends and family test for all inpatients that use QVH services. The NHS friends and family test was introduced in April 2014. All patients discharged from an adult inpatient ward are given a questionnaire asking if they would recommend QVH to their friends and family based on their experience in the hospital on a scale from 'extremely likely' to 'extremely unlikely'. Patients also have an opportunity to add comments and give reasons for their answer. The test is based on the 'net promoter score' survey used by commercial companies. The percentage who would not recommend is subtracted from the percentage that would, providing a score of between -100 and +100.

During 2013/14 we rolled out the friends and family test to our minor injuries unit, some of our outpatient clinics and the day surgery unit. During 2014/15 we hope to continue this roll out to the remainder of our outpatient clinics including physiotherapy and burns assessment clinics. We will also be rolling out the friends and family test for staff in 2014.

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

Patient experience indicator and why we measure it	How the data is collected	Target	Benchmark	2010/11	2011/12	2012/13
Failure to deliver single sex accommodation (occasions)	Continuous internal audit	0	N/A	0	0	0 G
Comment: In all wards, outside of theatre recovery areas and critical care, we endeavour to deliver care in male and female segregated wards or bays. Failure to meet this requires formal reporting. We are pleased to have been able to maintain segregated accommodation during 2013/14 and this has been achieved because we have a number of single rooms available for use.						
Complaints per 1000 spells	Continuous internal audit	<5 per 1000 spells	N/A	4.4	4.4	4.7 G
Comment: We monitor complaints about the quality of service we provide to help us continuously improve. All of our complaints are reviewed by the executive team and all complaints are investigated. If the complainant remains dissatisfied we will actively support them in going to the ombudsman for assurance that their complaint has been appropriately responded to. We are reviewing our current complaints handling policy to ensure we are following all of the best practice recommendations from the national report Putting patients back in the picture. That our complaint numbers have increased slightly is viewed positively as we believe it means that patients have felt confident in raising issues with us. This in turn offers us an opportunity to investigate and implement changes for the benefit of all patients.						
Claims per 1000 spells	Continuous internal audit	<1	N/A	0.8	0.7	1.0 G
Comment: This reflects legal action against the trust by patients/carers, and includes all cases, whether founded or unfounded. All findings from claims is fed back to the consultant involved. During 2013/14 we intend making this information more widely available so that others can learn from incidents where a claim is upheld.						
Overall experience	National inpatient survey	>9	Range 7.2-9.1 2013	N/A	9.0	8.9 A
Comment: This was a new measure from the national NHS inpatient survey that was introduced last year. QVH are pleased to have maintained a high score and will aim to continue to provide an improving experience for patients.						
Percentage of patients who felt they were always treated with respect and dignity	National inpatient survey	10	9.7 highest national score 2012	9.7	9.6	9.6 G
Comment: Patients continue to report that they are treated with dignity and respect at QVH.						

Patient experience indicator and why we measure it	How the data is collected	Target		2011/12	2012/13	2013/14
PLACE scores (these have replaced the PEAT scores)	National Reporting Learning Service	Excellent				A
				2011	**2012**	**2013**
Environment				Good	Good	98.9%
Food				Excellent	Excellent	81.3%
Privacy, dignity and wellbeing				Excellent	Excellent	91.2%
Condition, appearance and maintenance				N/A	N/A	90.7%
Comment: PLACE is an annual assessment of inpatient healthcare sites in England with more than 10 beds. It is self-assessed and inspects standards across a range of factors including food, cleanliness, infection control and patient environment (including bathroom areas, décor, lighting, floors and patient areas). Overall we scored well although food is noted – both through this assessment and patient surveys - as an area where we can improve further.						
Responsiveness to inpatients' personal needs		>82	76.9 national average 2013 Range 72.8-86.3 Surrey & Sussex Area Team	87.8	88.2	86.3 G
Comment: This is an amalgamated score from five questions within the national NHS inpatient survey. QVH continues to monitor staff awareness of the expectation that delivering excellent care should be a priority for everyone, and is rolling out further awareness sessions linked to the Chief Nursing Officer's 6Cs.						
***NHS friends and family test**	NHS friends and family test average score over the year	>80	2013-14 range for acute specialist trusts 62-97	N/A	N/A	86 G
Comment: QVH considers that this data is as described for the following reasons: The NHS friends and family test was introduced in April 2014. All patients discharged from an adult inpatient ward are given a questionnaire asking if they would recommend QVH to their friends and family based on their experience in the hospital on a scale from 'extremely likely' to 'extremely unlikely'. Patients also have an opportunity to give reasons for their answer. The test is based on the 'net promoter score' survey used by commercial companies. The percentage who would not recommend is subtracted from the percentage who would, providing a score of between -100 and +100. QVH intends to take the following action to improve this score and so the quality of its services by continuing to provide feedback questionnaires to patients and providing information back to staff on patient views of the services they received.						
Percentage of patients who rated their quality of care as good or excellent	NHS friends and family test	>95%		99%	99%	98% G
Comment: We invite all inpatients to complete a questionnaire about their quality of care on discharge. This score is taken from the NHS friends and family test question which asks if patients would recommend the ward they visited to their family and friends and provides a percentage score rather than a 'net promoter score' which some people find difficult to interpret.						
Percentage of patients who reported sufficient privacy when discussing their condition or treatment	National inpatient survey 2013	>9	9.8 highest score achieved in national inpatient survey 2013	9.7	9.3	9.0 G
Comment: That patients felt their privacy was respected when discussing their condition is a key measure of the quality of care delivered. We will work with patients and staff to see how this could be further improved.						

Satisfaction with anaesthetic service	National inpatient survey 2013	>9	9.6 highest score achieved in national inpatient survey 2013	9.2	9.6	9.2 G
Comment: This year we have taken information on satisfaction with our anaesthetic services from the national inpatient survey and the question 'Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?'						
***Staff recommendation of the trust as a place to work or receive treatment**	National staff survey	>4	4.08 national average acute specialist trusts 2013 (highest 4.33)	4.02	4.24	4.26 G
Comment: QVH considers that this data is as described for the following reasons: data is taken from the NHS staff survey results. This indicates an employee's view of the quality of care delivered by their organisation (scale 1-5). QVH intends to take the following actions to improve this score and so the quality of its services by continuing to work with staff and patients to ensure we are able to deliver the best care possible for patients. During 2013/14 we have commenced recruitment linked to the trust's values so we can be sure that the staff we employ believe in delivering compassionate care to patients.						

Statements from third parties

Statement from Healthwatch West Sussex

Healthwatch West Sussex welcomes the emphasis given to the importance of patient survey results in the chief executive's statement in the quality accounts and the commendable feedback from patients on the quality of service received. The annual inpatient survey for 2013 scored QVH as top out of all acute hospital trusts in England for how well patients rated their experience of being in hospital. Healthwatch West Sussex commends the trust on this exceptional result and in particular for scores on the quality of nursing, quality of care and treatment and support of patients on leaving hospital.

We commend the comprehensive data presented on patient experience but we would emphasise the importance of independent patient involvement in reviewing relevant processes, for instance in assessing the quality of the patient environment through the annual PLACE audits. With this in mind, we are disappointed at the lack of engagement with the trust on significant issues such PLACE audits (where trusts should be initiating contacts with Healthwatch for the supply of patient assessors) and the quality acounts prioritisation and criteria selection process itself, despite email contact from Healthwatch West Sussex last year. Healthwatch West Sussex looks forward to a marked improvement in its contacts with the trust next year and jointly reviewing performance from the patient and public perspective.

Statement from West Sussex Health & Adult Social Care Select Committee

Thank you for offering the West Sussex Health & Adult Social Care Select Committee (HASC) the opportunity to comment on QVH's quality account for 2013/14.

Overall, we do not necessarily find the quality account format very 'user friendly' – but understand that you are following national requirements. Quality accounts tend to be too long and too detailed to provide the kind of information that is readily digestible by the public and lay-people.

However, your quality account for 2013/14 provides thorough and clear information on the quality and performance of services. You are to be commended for the high rating QVH has achieved in both patient and staff surveys and for the strong performance you have demonstrated against your key priorities for 2013/14. You have explained measures taken to address areas where you have performed less well, and demonstrated good improvement in these. You have a strong focus on patient safety, outcomes and experience which is reflected in your proposed priorities for 2014/15.

From the HASC's perspective, a priority for the future must be ensuring safe, high quality services that are sustainable and deliverable for the future. This is not something you can achieve in isolation – it will require the whole health and social care system to work together to meet the challenges of increasing demand, pressure on services and financial constraints.

Statement from Crawley, Horsham and Mid Sussex Clinical Commissioning Groups

Crawley, Horsham and Mid Sussex Clinical Commissioning Groups have reviewed the quality account and are agreed that the document meets the Department of Health national guidance on quality account reporting.

As far as we can ascertain the information provided is accurate and complies with information provided by you to the CCGs, in addition to the nationally published data available.

The document provides clarity on the directors and staff involved in compiling the quality account. It might be beneficial as a public facing document to emphasise any patient or member involvement in fashioning the account.

Performance against 2013/14 priorities

The CCGs commend the trust on the high quality of care provided and are pleased to note that areas where improvement is needed are highlighted and appropriate action taken. The positive staff and patient surveys are good indicators of an organisation striving for continuous improvement.

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

Although all last year's priorities were not achieved it is helpful to know that they will continue to be monitored and acted upon through normal trust governance processes.

The priorities for 2014/15 appear appropriate in this context, and reflect the need to address areas needing more accelerated improvement. The nursing work on safe staffing will provide assurance that the skill and ratio numbers of nursing staff meets the needs of the patient group concerned. It is an important plank in the Francis report recommendations and would be in line with maintaining the excellent nursing reputation of the trust.

The quality account makes reference to the roll out of the friends and family test for staff in 2014, however it would also be useful to see how the workforce will be managed, supported and engaged. The trust has a Manchester Patient Safety Framework (MaPSaf) CQUIN agreed for 2014/15 to assist the organisation to reflect on their progress in developing a safety culture, through a programme of workshop discussions about the strengths and weaknesses of the culture in teams and/or organisations. It will therefore be of interest to see how outcomes of this triangulate with outcomes from the staff friends and family and other staff experience metrics.

The occurrence of 'never events' at QVH is of significant concern to the CCGs. The achievement of the performance relating to theatre lists starting with a surgical team safety briefing is welcomed, and the CCGs look forward to improved performance in the use of the WHO Safer Surgical checklist to minimise the risk of further occurrence.

It is noted that the prevalence of pressure damage has increased in 2013/14. Whilst the majority of these are as a result of prolonged surgery, the CCGs are encouraged by the work of the patient safety forum to identify further preventative measures, and look forward to the outcomes of these discussions.

The report recognises that further work is required to ensure that nutritional assessments are undertaken within 24 hours of admission, and therefore we welcome the enhanced reporting for the Safety Thermometer and ward safety dashboards. In addition however, it would be of interest to understand what processes are being put into place to improve performance in the ward areas.

The 'See and Do' clinics fit well into the outpatient reforms outlined in the document. It will be a test of the ability to meet patient demand whilst also introducing considerable consultant behaviour change aligned to streamlined outpatient processes. The CCGs look forward to supporting the trust in this improvement initiative.

The data presented and the use of RAG rating is helpful and provides a good visual picture of progress against last year's standards.

Conclusion

The trust has made good progress with its priorities and has been deemed above average in several categories. It has several challenges common to all health care organisations however, and will be challenged in the year ahead to further improve quality whilst maintaining financial stability.

The priorities for 2014/15 appear realistic in this respect and show that the trust is taking account of patient feedback whilst also planning ahead for better managed services and care pathways.

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

Statement from QVH Council of Governors

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

A governor representative attends the meetings of the board of directors, reporting back to the governors. Similarly a governor attends the meetings of the quality and risk committee which reviews all quality and risk activities within the trust on behalf of the board. One governor is responsible for the overview of the activities of the external auditors and the audit committee and is also on a board of directors' working group which reviews the effectiveness of board financial and operational reporting.

The governors' steering group meets monthly with the executive reviewing operational reports and discussing any issues arising. There are regular patient experience reports which cover all aspects of the patient experience and are presented to the board of directors and the council of governors. Governors attend meetings of the patient experience group chaired by the director of nursing, which monitors patient experience and maintains an action plan for improvements. There are other areas of involvement including individual governor tours of specific areas of the hospital and governor attendance on some of the regular management inspections which cover cleanliness and safety issues within all departments of the hospital.

During 2013/14 QVH has commenced a schedule of regular 'compliance in practice' assessments of all clinical areas. Governors are part of the teams which undertake the assessments. The assessments review safety of patients, how their needs are met, whether their care has been individually tailored, responsiveness to individual patients' needs and the effectiveness of leadership and management. During the assessment patients and staff are interviewed and patient records are reviewed.

During 2013/14, the governors have been very pleased to note the results of the national inpatient and outpatient surveys undertaken throughout the NHS. QVH has maintained consistently high scores on these surveys and continues to work to improve those areas which do not have the highest scores.

The work the governors undertake gives us a clear and comprehensive view of the activities within QVH and of the quality of the patient experience. We have reviewed the quality accounts produced for 2013/14 and are satisfied that they give an accurate and reliable picture of the quality of QVH's activities. We also agree with the priorities for improvement in 2014/15. The governors have always paid particular attention to the performance of the outpatient clinics and are pleased with the number of initiatives introduced in 2013/14 which have helped improve the patient experience.

The management, staff and governors of QVH take pride in the high standard of care being achieved within the hospital. However, QVH is constantly striving to improve further. The governors remain confident that QVH has the highest quality of care as a key priority and that it will continue to maintain and improve upon the current excellent standard.

Performance against key national targets for 2013/14

	Measure	Target	2013/14	
Clostridium difficile infections	Count	0	1*	Green
MRSA bacteraemia	Count	0	0	Green
Cancer: 2 week wait from urgent GP referral to date first seen	%	93%	96.8%	Green
Cancer: 31 day wait from diagnosis to first treatment	%	96%	96.9%	Green
Cancer: 31 day wait for second or subsequent treatment - surgery	%	94%	97.8%	Green
Cancer: 62 day wait from urgent GP referral to treatment	%	85%	89.9%	Green
Cancer: 62 day wait (upgraded to urgent after referral)	%	N/A	97.7%	No target
Cancer screening: 62 day	%	N/A	50%	No target
Attendees seen within 4 hours in minor injuries unit	%	95%	99.6%	Green
18 week referral to treatment - admitted	%	90%	90.5%	Green
18 week referral to treatment - non-admitted	%	95%	96%	Green
18 week referral to treatment - incomplete pathways	%	92%	93.8%	Green
Receving diagnostic test within 6 weeks	%	99%	100%	Green
Cancellations on the day of operation	Count	N/A	38	No target

*Target met because below *de minimis* of 12.

Statement of director responsibilities in respect of the quality report

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

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

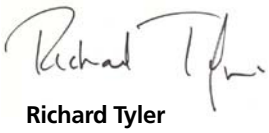
In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2013-14*;
- 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 2013 - May 2014
  - papers relating to quality reported to the board over the period April 2013 - May 2014
  - feedback from commissioners dated 20 May 2014
  - feedback from governors dated 21 May 2014.
  - feedback from Healthwatch West Sussex dated 15 May 2014.
  - feedback from the Health and Adult Social Care Select Committee dated 20 May 2014
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2014
  - QVH national inpatient survey results, April 2014
  - QVH national staff survey results, February 2014
  - the head of internal audit's annual opinion over the trust's control environment dated 14 May 2014
  - CQC quality and risk profiles (now hospital intelligent monitoring report) dated February 2014
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the quality report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm they are working effectively in practice;
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions and is subject to appropriate scrutiny and review; and
- the quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report (both available at www.monitor-nhsft.gov.uk/annualreportingmanual).

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

By order of the board,

Peter Griffiths
Chairman
28 May 2014



Richard Tyler
Chief Executive
28 May 2014

Independent auditors' report to the council of governors of Queen Victoria Hospital NHS Foundation Trust

We have been engaged by the council of governors of Queen Victoria Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Queen Victoria NHS Foundation Trust's quality report for the year ended 31 March 2014 (the "quality report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 62 day cancer waits – the percentage of patients treated within 62 days of referral from GP; and
- Emergency readmissions within 28 days of discharge from hospital.

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

Respective responsibilities of the directors and auditors

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

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

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

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

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

- Board minutes for the period April 2013 to May 2014;
- Papers relating to quality reported to the board over the period April 2013 to May 2014;
- Feedback from the commissioners dated 20 May 2014;
- Feedback from local Healthwatch organisations dated 15 May 2014;
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2013/14;
- The 2013/14 national patient survey;
- The 2013/14 national staff survey;
- Care Quality Commission quality and risk profiles/intelligent monitoring reports 2013/14; and
- The 2013/14 head of internal audit's annual opinion over the trust's control environment.

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

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

This report, including the conclusion, has been prepared solely for the council of governors of Queen Victoria Hospital NHS Foundation Trust as a body, to assist the council of governors in reporting Queen Victoria Hospital NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the annual report for the year ended 31 March 2014, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the council of governors as a body and Queen Victoria Hospital NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

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

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

Limitations

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

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

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

- the quality report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the quality report is not consistent in all material respects with the sources specified above; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual*.

KPMG LLP, Statutory Auditor
15 Canada Square, London, E14 5GL
May 2014

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

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

We are a centre of excellence, with an international reputation for pioneering advanced techniques and treatments.

Everything we do is informed by our passion for providing the highest quality care, the best clinical outcomes and a safe and positive patient experience.

You can find out more at **qvh.nhs.uk.**

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