Queen Victoria Hospital
NHS Foundation Trust

Quality Accounts
2014/15

Contents

Part 1: Statement on quality

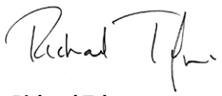
Chief executive's statement

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

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

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

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



Richard Tyler
Chief Executive

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

Performance against 2014/15 priorities

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

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

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

Priority 1

Provision of clinical outcome measures

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

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

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

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

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

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

- Breast reconstruction developed a local database which incorporated clinical details and patient feedback. Unfortunately this database could not be linked to existing trust IT systems for patient demographics. Introduction of a new PROM registry by the British Association of Plastic Reconstructive and Aesthetic Surgeons has negated the further development of this local database.
- Anaesthetics developed a local database which incorporated clinical details. As with the breast database, there were similar IT challenges which were recognised early on in the project. Additional resources were acquired which enabled more comprehensive data collection. The collection of this data is now embedded and outcomes data will be available during 2015/16.
- Burns data proved very challenging to collate by consultant due to the multidisciplinary nature of the care, with multiple surgeons involved, and the length of treatment. Interrogation of the IBID database designed for commissioning purposes continues as this contains clinical outcomes. This will remain as part of our routine quality account review by service and key measures have been identified from this to be used to facilitate national comparison.
- Eye service consultants have joined a national website, www.iwantgreatcare.org which enables patients to provide feedback about individual doctors. Whilst this provides PROM measurement by consultant, not every patient chooses to provide feedback so it has not been counted as a fourth published outcome measure. However, this feedback option is available for all doctors and the eye consultants are actively encouraging other consultants to promote and use this service and the trust has added this link to its website.

Priority 2

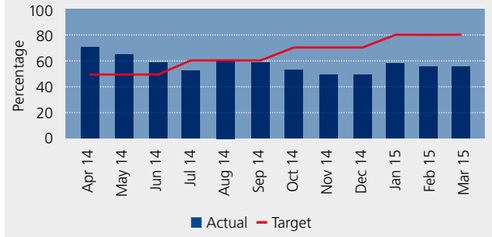
Scheduling of elective surgery

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

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

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

Percentage of patients with at least three weeks' notice of elective surgery date



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

Operations cancelled for non-clinical reasons

Priority 3

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

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

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

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

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

Priority 4

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

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

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

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

Priorities for 2015/16

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

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

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

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

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

Priority 1

Scheduling of elective surgery

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

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

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

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

Priority 2

Expand trauma capacity to reduce waits for trauma surgery

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

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

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

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

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

Priority 3

Improving patient experience of QVH food

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

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

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

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

Statements of assurance from the trust board

Review of services

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

Review of quality of care

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

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

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

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

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

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

Participation in clinical audits

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Participation in clinical research

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

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

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

Use of the Commissioning for Quality and Innovation payment framework

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

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

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

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

Care Quality Commission registration and periodic and special reviews

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

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

Data quality

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

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

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

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

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

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

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

Part 3: Review of quality performance 2014/15

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

Patient safety

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

Monitoring the prevention of harm and the rigorous investigation of all patient harm and clinical incidents provides opportunities to learn and minimise the risks of similar events happening again. Patient safety is included within our key strategic objective of 'outstanding patient experience' where patients are at the heart of safe, compassionate and competent care provided by well-led teams in an environment that meets the needs of patients and their families.

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

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

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

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

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

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

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

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

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

Clinical effectiveness

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

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

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

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

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

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

Burns service

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

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

Survival rate

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

Clinical effective indicators

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

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

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2012	2013	2014
Average length of adult inpatient stay (bed days) per percentage burn for acute injury admissions	Prospective database of adult burns	<65 years old - 1 day per 1% burn	N/A	1.5 days	1.6 days	1.6 days
		>65 years old - 2 days per 1% burn	N/A	2 days	3.6 days	2.7 days
Average length of paediatric inpatient stay (bed days) per percentage burn for acute injury admissions	Prospective database of paediatric burns	<16 years - 2 days per 1% burn	N/A	0.8 days	1.1 days	0.6 days
Comment: The target length of inpatient stay of burns patients is related to the size of their burn, measured as a percentage of their body surface area. We aim that, on average: • Adult patients between the ages of 17 and 65 years of age should require a one-day inpatient stay per 1% burn. • Adult inpatients over 65 years should require a two-day inpatient stay per 1% burn. Over 65 the length of stay is often complicated by the higher prevalence of co-morbidities among this age group and the requirement for complex social care packages which take time to arrange. • Paediatric inpatients between 0 and 16 years of age should require a two-day inpatient stay per 1% burn.						

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

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

Breast surgery

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

Breast reconstruction after mastectomy using free tissue transfer – flap survival

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

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

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2012/13	2013/14	2014/15
Breast reconstruction after mastectomy using free tissue transfer – flap survival	Continuous prospective electronic database	100%	95–98% (published literature) 98% BAPRAS 2009	99.44%	98.94%	100%
Comment: Our total failure rate was zero, this compares favourably with last year (1.06%). This is well below the national quoted rates of 2%.						

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

Hand surgery

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

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

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

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

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

Skin cancer care and surgery

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

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

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

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

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

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

Head and neck

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

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

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

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

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

Orthognathic treatments

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

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

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

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

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

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

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

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

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

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

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

Clinical effectiveness indicator	How the data is collected	Target	Benchmark	2012/13	2013/14	2014/15
% of patients who were completely/fairly satisfied	Patients asked at the end of treatment to complete a questionnaire in hospital and review their whole treatment period	95%	N/A	N/A	100%	100%
% of patients agreeing teeth were as straight as hoped for		95%	N/A	N/A	97%	98%
% of patients glad they had the treatment		95%	N/A	N/A	97%	98%

Comment: Every patient who has finished orthodontic treatment completes a questionnaire privately and digitally, directly into our outcomes kiosk. In addition to the key PROMs detailed above, 94% of patients were happy with the appearance of their teeth after treatment, 84% reported improved self-confidence, and 94% would recommend a similar course of treatment to a friend.

Mandibular advancement splint (new measure)

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

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

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

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

Comment: There was an 80% resolution in apnoeic symptoms.

Corneoplastic and oculoplastic surgery

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

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

Clinical effectiveness indicator	How the data is collected	Target	Benchmark	2012/13	2013/14	2014/15
Percentage of patients achieving vision better than 6/12 after cataract surgery without other eye disease	Annual audit of 100 patients	100%	96% (UK EPR)	100% with correction 90% unaided	100% with correction 90% unaided	100% with correction 92% unaided

Comment: There were 1,106 cases of phacoemulsification for cataracts recorded in 2014. Departmental audit shows that cases of post-operative eye infection are extremely rare and well below national average rates. We monitor the number of these patients who achieve significant improvement to the vision in that eye.

Sleep

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

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

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

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

Clinical effectiveness indicator	How the data is collected	Target	Benchmark	2012/13	2013/14	2014/15
Percentage reduction in daytime sleepiness - pre/post Epworth Sleepiness Score (mean score)	Demographically representative random audit of 100 patients using CPAP equipment	N/A	N/A	N/A	N/A	59%
Drop in Epworth Sleepiness Score amongst patients with an initial score higher than 10 (mean score)		N/A	N/A	N/A	N/A	10.3%
Comment: This is the first time this audit has been completed in this way at QVH. We will regularly measure the ESS to ensure patients continue to benefit from this treatment. Sleep at night is essential for good health and excessive sleepiness during the day reduces quality of life and is associated with harm to individuals (such as falls and driving accidents). The respiratory dysfunction which can be associated with these symptoms can also cause hypertension and the onset of diabetes which can also lead to cardiovascular sequelae.						

Anaesthetics

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

Clinical effectiveness indicator	How the data is collected	Target	Benchmark	2012/13	2013/14	2014/15
Percentage of patients requiring no recovery room intervention following anaesthesia	Continuous prospective audit of all inpatient recovery room procedures. 2014/15 data relates to data from Feb-Mar 2014 and Jun-Dec 2014	100%	N/A	84%	88%	88%
Comment: The anaesthetic recovery room exists to ensure that patients are fit to discharge to the ward following surgery. We monitor all interventions that are made in recovery, including medical review, intravenous analgesia, unexpected discharge to critical care and all complications such as hypothermia or airway difficulties.						

Patient experience

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

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

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

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

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

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

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

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

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

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

National and local quality indicators for external audit

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

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

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

Patient safety indicator	How the data is collected	Target	Benchmark	2012/13	2013/14	2014/15
Cancer						
62 day wait from referral to definitive cancer treatment	Data is collected monthly and reported quarterly. Information is obtained through tracking patients from referral to definitive cancer treatment and includes liaison with other shared care providers.	85%	85%	92.5%	89.3%	87%
18 weeks						
Incomplete pathways	Data is collected and reported one month in arrears monthly via the RTT waiting list for 18 weeks which has been validated.	92% per month	92%	94%	93.8%	93.5%
Cancelled operations						
All patients cancelled each month, for non-clinical reasons regardless of when they were cancelled.	Data is collected from the PAS systems and reported each month. Data is collected from information contained with the theatre system and then validated before being reported monthly. The compliance with 28 days is monitored and recorded via information from theatres and PAS systems.	<118 per month for Q1; less than 79 per month for Q2-Q4	Local benchmark			Target for year was less than 1,065; actual for year was 1,027
Patient cancelled on the day of surgery for non-clinical reasons who does not meet the 28 day guarantee					3 (data from Oct 2013-Mar 2014)	3
Urgent operations that have been cancelled for non-clinical reasons for a second or subsequent time					5 (full year data)	3

Comment: The baseline for all hospital non-clinical cancellation was established at the end of Q1 averaging around 118 per month. In Q2 this rose to an average of 144 per month with a peak in September of 184. The increase in cancellations in Q2 was predominately due to significant recruitment issues with junior doctors reducing theatre capacity available and a higher number of urgent cases that take priority. The target for reducing cancelled cases per month for non-clinical reasons was 118 per month in Q1 and 79 per month in Q2-Q4.

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

Performance against national targets

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

Statements from third parties

Statement from Healthwatch West Sussex

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

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

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

Statement from West Sussex Health & Adult Social Care Select Committee

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

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

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

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

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

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

Performance against 2014/15 priorities

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

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

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

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

Priorities for 2015/16

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

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

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

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

Conclusion

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

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

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

Statement from QVH Council of Governors

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

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

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

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

Statement of director responsibilities in respect of the quality report

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

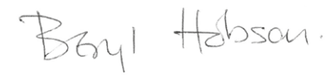
Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

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

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

By order of the Board,



Beryl Hobson
Chair
28 May 2015

Richard Tyler
Chief Executive
28 May 2015

Independent auditor's report to the council of governors

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

Scope and subject matter

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

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

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

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

Respective responsibilities of the directors and auditors

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

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

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

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

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

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

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

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

This report, including the conclusion, has been prepared solely for the council of governors of Queen Victoria Hospital NHS Foundation Trust as a body, to assist the council of governors in reporting the NHS foundation trust's quality agenda, performance and activities. We permit the disclosure of this report within the annual report for the year ended 31 March 2015, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the council of governors as a body and Queen Victoria Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

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

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

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

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

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

Conclusion

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

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

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

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.**

Queen Victoria Hospital NHS Foundation Trust
Holtye Road
East Grinstead
West Sussex RH19 3DZ

T 01342 414000
E info@qvh.nhs.uk
W www.qvh.nhs.uk