Queen Victoria Hospital
NHS Foundation Trust

Quality Accounts
2015/16

Contents

Statement on quality

QVH 2020: Delivering Excellence is our shared vision for continued success at QVH over the coming years. It is based on the straightforward belief that continually striving to deliver excellence is the most effective way of ensuring that QVH continues to thrive.

As a trust we were therefore very pleased with the overall 'good' rating we received from the CQC and particularly proud to be rated 'outstanding' for patient care. This is a testament to our commitment to providing expert and compassionate care and to our values of humanity, pride and continuous improvement.

Maintaining high quality services relies upon continual day-to-day improvements alongside longer-term strategic developments. In 2015/16 we made good progress against our quality priorities with steady improvements in patient food and the expansion of trauma capacity. In addition, we have been supporting broader improvements across the health service as a whole with increased research output and greater numbers of patients taking part in research studies.

"We were very pleased with the overall 'good' rating we received from the CQC and particularly proud to be rated 'outstanding' for patient care."

Quality improvements have been underpinned by our clinical governance systems and processes, both of which are fundamental to the delivery of high quality care. During the year, we undertook an extensive review of these systems, leading to considerable improvements.

Looking to the future, I am confident that we have the necessary priorities, processes and plans in place to further improve our patients' care and hospital experience as we continue striving to deliver excellence.

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

Richard Tyler
Chief Executive

Priorities for improvement

QVH's quality priorities for 2016/17

Priorities for 2016/17 have been influenced by progress on our 2015/16 priorities and patient feedback. They have been developed in collaboration with all staff, the council of governors and our lead clinical commissioning group through their contributions to our long-term strategic plan.

Priorities are built around our ambitions and intention to deliver safe, reliable and compassionate care in a transparent and measurable way.

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

Patient safety

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

Clinical effectiveness

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

Patient experience

Meeting our patients' emotional as well as physical needs.

Our clinical priorities and why we chose them	What success will look like
Patient safety	
Reduce the investigation time for incidents from the current average of 60 days to 30 days, in line with national targets to improve safety and learning from incidents We want to improve the time taken to report all incidents to the National Reporting and Learning Service (NRLS) by decreasing the number of days it takes us to do this.	QVH has set local targets to exceed the national recommendation of investigating incidents within 30 days. Incidents categorised as 'no harm', 'near miss' and 'minor harm' will be reported consistently within 10 working days in 90% of cases. Those incidents causing 'moderate', 'major' and 'catastrophic harm' will be reported within 20 working days in 80% of cases.
Clinical effectiveness	
Proactive audit of compliance with 20% of applicable NICE clinical guidelines and quality standards QVH is committed to ensuring that services take into account national guidance and embed the latest evidence-based practice into the care and treatment of our patients. We have chosen to review and audit compliance with 20% of our key National Institute for Health and Care Excellence (NICE) guidelines to measure compliance with their recommendations and identify any areas that require focussed attention or improvement. Guidance for auditing has been prioritised following a review by the medical director, director of nursing and the head of quality and compliance.	From 2001 until March 2016, NICE has published 21 quality standards and 44 clinical guidelines relevant to services provided by QVH. Clinical audit projects will be completed for a minimum of 20% of these quality standards and clinical guidelines.
Patient experience	
Improve signage and walkways While patients tell us that the standard of care they receive across our services is very high, and they praise staff for the kindness and compassion they receive, some patients comment that they have difficulty finding departments and navigating the site. We have chosen to make it a priority to improve wayfinding for patients and visitors.	By the end of quarter 2, improvements to the covered walkway surfaces will have started. In addition to resurfacing, we will ensure that the walkways meet dementia standards. We will remove obsolete signs and put up new signage as appropriate. In addition, a wayfinding strategy will be included within the estates improvement plan and any future estates developments will include wayfinding options.

Performance against 2015/16 priorities

Priorities for 2015/16 were influenced by information from national and local reports and audit findings along with the views of governors, the programme board (which includes representation from Crawley and Horsham and Mid Sussex CCGs), our lead clinical commissioning group, patient feedback and suggestions from staff across the organisation.

End of year progress against our three 2015/16 qualities priorities was as follows:

1. Scheduling of elective surgery

We aimed to increase the percentage of elective patients booked with at least three weeks' notice to ensure they had time to plan their personal commitments accordingly. We have not achieved the target for this priority, although there has been considerable work to improve the management of activity and on the application of the access policy.

Patients are treated in clinical priority and strict date order, both of which are key quality issues. However, during the past year, the trust has worked to ensure that any bookings cancelled are fully utilised as far as possible. It is not uncommon for patients to ask to cancel or reschedule at relatively short notice for a variety of reasons. When a patient cancels or reschedules at short notice, or is too unwell for surgery, we offer these short-notice appointments to other patients. While this is effective booking management, it will mean that these patients are given less than three weeks' notice. Patients are placed under no pressure to take a short-notice booking and many patients are happy to take up this offer.

In order to improve efficiency and patient experience we have also piloted a new way of booking some skin patients in the outpatients department. We offered patients a date for surgery at their outpatient appointment, starting with the first available slot. Some patients chose dates for surgery that gave less than three weeks' notice because this best met their needs. This was a popular and successful initiative and will be rolled out across other specialties during 2016/17 along with patient surveys to ensure we capture feedback on this offer. We have not met our original objectives for this priority but believe that the actions we have taken during the year have significantly improved patient experience.

Percentage of elective patients booked with at least three weeks' notice 2015/16

Month	Target	Actual
Apr 15	50%	53%
May 15	50%	55%
Jun 15	50%	54%
Jul 15	60%	55%
Aug 15	60%	60%
Sep 15	60%	60%
Oct 15	60%	48%
Nov 15	70%	49%
Dec 15	70%	46%
Jan 16	80%	59%
Feb 16	80%	57%
Mar 16	80%	58%

"Some patients chose dates for surgery that gave less than three weeks' notice because this best met their needs. We believe that the actions we have taken during the year have significantly improved patient experience."

2. Expansion of trauma capacity

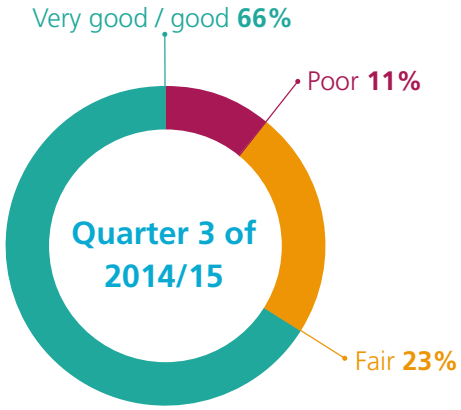
We aimed to increase capacity for trauma surgery so that 90% of patients would have their trauma surgery within 24 hours of admission. QVH began to offer additional capacity for trauma surgery from June and this was expanded further from September.

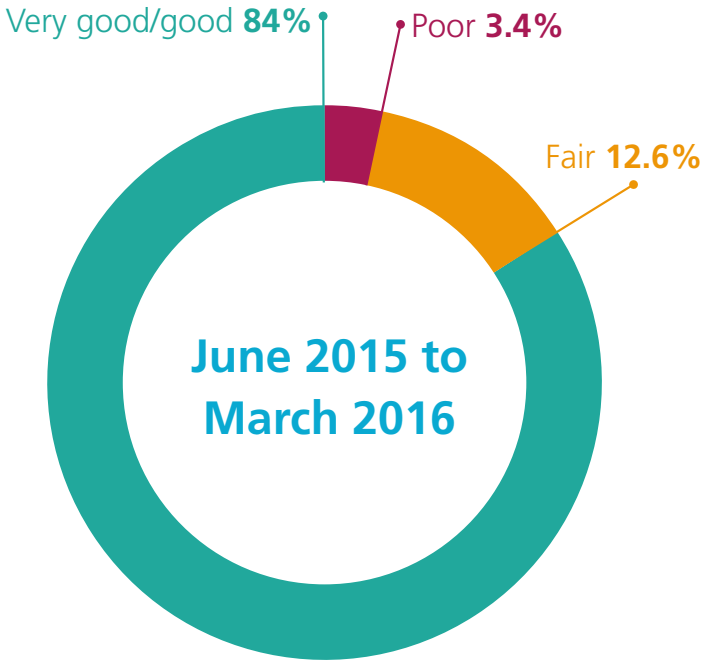
The number of trauma patients treated within 24 hours of admission improved from 85% in quarter 2 to 89% in quarter 3 but decreased slightly to 86% in quarter 4, just below the 90% target. In part this is due to the relatively small number of trauma operations having an impact upon the percentage.

We are continually looking at ways to improve and one initiative has been to enhance how we use the theatre co-ordinator role with the trauma team to improve communication and flow through theatre so patients can begin their surgery sooner.

Percentage of trauma patients undergoing first trauma surgery within 24 hours of admission

Month	Target	Actual
Apr 15	90%	90%
May 15	90%	79%
Jun 15	90%	81%
Jul 15	90%	82%
Aug 15	90%	87%
Sep 15	90%	86%
Oct 15	90%	87%
Nov 15	90%	88%
Dec 15	90%	92%
Jan 16	92%	86%
Feb 16	92%	85%
Mar 16	92%	88%





3. Improving patient experience of QVH food

We aimed to improve our patients' experience of QVH food as measured by the NHS friends and family test surveys. There has been steady progress on this throughout the year.

A detailed plan led by the head chef has improved the menu, the presentation of the food and the food temperature. A food task and finish group led by a matron and chaired by one of our public governors has concluded. As a result of this, new menus, new ways of serving food, new crockery and better communication between clinical areas and the kitchens have been introduced.

Our baseline in quarter 3 of 2014/15 was 34% of patients rating their food as 'fair' or 'poor' (of these 11% rated it as 'poor'). Our target for quarter 4 of 2015/16 was to have 'fair' or 'poor' ratings at 20% or less with 'poor' ratings not greater than 5%.

We achieved this target, with average ratings from June 2015 to March 2016 of 16% for 'fair' or 'poor' and only 3.4% 'poor'. Anecdotally, negative comments and complaints about the food from patients and relatives received on regular ward rounds by the director of nursing have significantly reduced and there are now occasional plaudits about the food.

Sign up to Safety campaign

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

During the year we have been working to reduce avoidable harm in the NHS by progressing our local adaptation of the Manchester Patient Safety Framework (MaPSaF) - a tool to help NHS organisations assess their progress in developing a safety culture - designing it to cover aspects such as medication errors and pressure damage. This adaptation of the tool will be completed during 2016 so that implementation can begin.

We have also put in place a number of improvements to our risk management processes. For example, within incident reporting, the trust's electronic system is now aligned to meet the Duty of Candour requirements, supplemented by an audit.

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

We have enhanced the support available for staff and the identification and dissemination of learning with the creation of a new Datix (our incident reporting system) users forum, additional risk management training and the development of a regular patient safety newsletter for staff. Learning aspects are discussed at a range of forums across the trust and at morbidity and mortality meetings.

Our Sign up to Safety pledges can be viewed on our website. Collectively, they are one of our local Commissioning for Quality and Innovation (CQUIN) targets for 2016/17.

Duty of Candour

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

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

We have always been committed to being open and honest with patients and have undertaken a number of initiatives to ensure that we are effective in embedding the Duty of Candour into our systems and processes, including:

- Our electronic incident reporting system is now aligned to the Duty of Candour to ensure that appropriate incidents are captured and the relevant healthcare professionals are notified that an incident has occurred so the necessary investigations can be undertaken.
- A patient information leaflet has been created to inform patients of what to expect and their rights if harm does occur.
- A programme of ongoing staff training has been established and will continue during 2016/17 to enable staff to support our patients effectively.

Patient safety achievements

2015/16 achievements	Further work for 2016/17
Safety standards for invasive procedures The introduction of the national and local safety standards for invasive procedures (NatSSIPs and LocSSIPs) has led QVH to build upon its work in 2015 to adapt, pilot and introduce the WHO surgical safety checklist to minimise risks and improve safety for patients undergoing minor procedures. We will continue to progress this work towards the September 2016 deadline.	We will continue to implement the standards in 2016/17 by reviewing current processes and ways of working to ensure the standards are embedded into practice. The standards will also be monitored and audited to ensure they continue to be embedded in the correct way to benefit patients. We will also continue in engage with other healthcare organisations and partners to share learning and our experiences of using these standards.
Identification and treatment of sepsis Sepsis is a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs. It can lead to shock, multiple organ failure and death, especially if not recognised early and treated promptly. Globally, sepsis remains the primary cause of death from infection despite advances in treatment and monitoring. QVH has introduced a new sepsis policy and pathway for use within the trust.	We will continue to screen all appropriate patients and initiate rapid treatment where required. We intend to measure our performance on a sample of cases against the NICE clinical guideline for sepsis management due to be released in July 2016.
'Human factors' training QVH has implemented a programme of human factors training with funding support from Health Education Kent, Surrey and Sussex. The aims are to help healthcare professionals to understand why errors are made; the 'systems factors' that can impact on patient safety; and to raise awareness of how their own attitudes and behaviours and those of others can be used to develop teams and improve the quality and safety of patient care. Human factors training has been specifically targeted at operating theatre staff. Alongside dedicated human factors training, QVH medical staff have led multi-disciplinary simulation training which pays heed to the human factors knowledge and skills required to function safely and effectively as individuals and a team.	We will further integrate human factors tools and methodologies into root cause analysis and incident investigations across the trust, to help improve the identification of errors and facilitate continuous learning.

Clinical effectiveness achievements

2015/16 achievements	Further work for 2016/17
Enhanced recovery after breast surgery QVH is continually seeking new and innovative ways to improve the experience and wellbeing of patients undergoing major surgery. The breast team has produced a multi-disciplinary Enhanced Recovery After Surgery (ERAS) guideline and pathway. Patients are actively encouraged to be aware of and participate in steps to improve the outcomes from their surgery. The aims of the ERAS pathway are to improve the quality of care and enhance the patient experience. The guideline and pathway ensure that patients receive consistent, evidence-based medicine to optimise the quality of care and return to normal life as quickly as possible after surgery.	An award-winning early audit of outcomes from the ERAS programme has shown some promising improvements and highlighted areas for future development. The breast team gathers data on a regular basis to assess the effectiveness of the pathway and learning is also used to inform other ERAS initiatives within QVH. The service will continue to work in conjunction with other centres to help build knowledge and understanding of ERAS for breast patients and further develop the pathway as necessary.
Enhanced recovery after head and neck surgery The QVH Enhanced Recovery Programme for Head and Neck Surgical Patients (ERPHN) aims to reduce the physical trauma of surgery. It is a collection of strategies in a structured pathway that supports the multidisciplinary team (surgical, anaesthesia, allied health professionals and ward staff) to work together to optimise patient outcomes, including early discharge where appropriate.	The use of this pathway and the benefits for patients will continue to be publicised. An audit will also be carried out to ensure the effectiveness of the pathway and to review its impact on patient care.
Sentinel node biopsy Sentinel node biopsy is a procedure in which the sentinel lymph node is removed and examined under a microscope to determine whether cancer cells are present. It is based on the idea that cancer cells spread (metastasize) in an orderly way from the primary tumour to the sentinel lymph nodes, then to other nearby lymph nodes. Radiolabelled sentinel node biopsy was first introduced to QVH in 2014/15 to assist in diagnosis and treatment of patients with breast cancer. This work required the complex interplay of specialities including breast and plastic surgery, operating theatres, medical physics and diagnostic imaging at remote sites to coordinate labelling with surgery. The effort required is justified by the improved quality of diagnosis and treatment offered.	Having already introduced radiolabelled sentinel node biopsy for breast surgery, QVH is now implementing this procedure for head and neck cancer. This will be conducted in accordance with NICE clinical guideline NG14, against which we will measure our services. In addition, as a separate piece of work, we are an indicator site for NICE to assess some of the challenges and learning from introducing their new guidelines into practice.

2015/16 achievements	Further work for 2016/17
Tracheostomy training QVH has devised a rolling programme of multi-disciplinary training for staff treating our complex head and neck patients. It meets the recommendations of the National Confidential Enquiry into Patient Outcome and Death's 2014 report *On the Right Trach? A review of the care received by patients who underwent a tracheostomy.* This training programme supports healthcare professionals to deliver the ERPHN.	The ongoing programme of training will continue, to ensure that healthcare professionals have the necessary knowledge and skills to provide the best care for patients.
Laryngectomy training QVH is a surgical centre for head and neck patients, a small patient group requiring highly specialised multidisciplinary care. We endeavour to continually broaden our knowledge and awareness of this patient group and a programme of ongoing laryngectomy training was formulated to support the teams caring for these patients. This training builds on the care provided by the ERPHN.	The training will continue, to further develop and widen the knowledge of the multidisciplinary team looking after this patient group and to increase awareness of the care they require.
Clinical electroporation We are well advanced in developing our patient pathways and staff training to enable us to commence electrochemotherapy treatment to skin nodules of the head and neck, with the business case and policy already approved. This new NICE approved treatment combines a low dose chemotherapy drug and an electrical pulse applied directly to the cancer cells. This allows more of the cancer drug to enter the cells with a dramatic increase in the effectiveness of treatment.	We will be updating the electrochemotherapy policy in May 2016 prior to commencing treatment of patients in the summer of 2016. We anticipate this service will also be rolled out to advanced melanoma and metastatic breast cancer patients in the future.

Patient experience achievements

2015/16 achievements	Further work for 2016/17
Butterfly Scheme for dementia patients In 2013, QVH introduced the Butterfly Scheme which empowers people with dementia and their carers to choose the care they want. Patients with a diagnosis of dementia or memory impairment, assisted by their carer, can choose to use a butterfly symbol to request dementia-specific care. During 2015/16 QVH has implemented its dementia strategy and all staff working in clinical areas have been taught essential skills to allow them to care well for these patients. The Butterfly Scheme is led by our dementia champions - staff with a particular interest in improving the care, support and experience for people with dementia. QVH has also signed up to John's Campaign, a UK-wide campaign for the rights of people with dementia to have their carers with them if they are admitted to hospital.	We will continue to focus on providing individualised care for people with dementia and their carers. We will continue to monitor a wide range of data and feedback to assess how well we are caring for these patients and to help us to make improvements where needed. John's Campaign has also been included as a CQUIN target for 2016/17. It will further develop a positive culture of knowledge, understanding and empathy across all staff groups.

"Patients with a diagnosis of dementia or memory impairment, assisted by their carer, can choose to use a butterfly symbol to request dementia-specific care."

2015/16 achievements	Further work for 2016/17
#hellomynameis Since January 2015, QVH has been signed up to the #hellomynameis campaign which was started by Dr Kate Granger, a terminally ill cancer patient. Kate observed that many staff did not introduce themselves before delivering care and thought that this should be a basic step in communication with patients. At QVH we pride ourselves on delivering a warm welcome to our patients and patient-facing staff have been given badges with their names on to facilitate interaction with patients and support the campaign.	Work on the campaign will continue in 2016/17 and badges will be rolled out to administrative and support service staff.
CREW camp for paediatric patients CREW (challenging, recreational, educational weekend) is a unique support programme for up to 30 paediatric patients who have experienced burns injuries. A charitable initiative in collaboration with the community, it offers these patients an opportunity to meet others, share experiences and improve self-esteem. The focus on physical challenges is based on evidence that if young people with scars - who may not feel good about how their bodies look - feel good about what their bodies can do, they can develop a better body image and higher self-esteem.	We will continue to work with the local community to secure funding so that this initiative can continue.
Improved patient experience of food Historically, patient feedback indicated that QVH food was not meeting the expected standards and this was made a quality priority for 2015/16. A task and finish group led by a matron and a public governor and reporting to the patient experience group resulted in the implementation of a number of initiatives, including: • A red tray system to indicate patients who require help with feeding • New crockery to support patients with dementia • New weekly menus • New food trolleys that better maintain temperature and hold more food choices.	We will continue to monitor satisfaction with food through patient surveys and benchmarking against our peers. The trust's nutrition nurse will undertake an additional inpatient food survey in conjunction with dietetics and matrons and seasonal menus will be audited bi-annually.
New patient and visitor lounge During 2015/16, QVH opened the Lancaster Lounge, a new coffee lounge and eating area for patients and visitors. Situated in Canadian Wing, it was generously funded by the QVH League of Friends. RAF nurses based at QVH also raised the necessary funds to refurbish the military plaques that hang beside the Guinea Pig Club roll of honour opposite the entrance to the new lounge.	We will continue to monitor feedback to ensure that the Lancaster Lounge and our other facilities for patients and visitors continue to meet their needs.

Statements of assurance from the board

Review of services

During 2015/16, Queen Victoria Hospital NHS Foundation Trust provided 20 NHS services including burns care, general plastic surgery, head and neck surgery, maxillofacial surgery, corneoplastic surgery and community and rehabilitation services. QVH has reviewed all the data available to it on the quality of care in all of its NHS services. The income generated by the relevant health services reviewed in 2015/16 represents 90% of the total income generated from the provision of relevant health services by QVH for 2015/16.

"Research sits at the heart of the trust's vision. Participation in research helps our staff stay abreast of the latest treatment possibilities and enables us to deliver improved patient outcomes."

Research

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

We have a joint appointment with the University of Brighton at the grade of senior lecturer. This post has been instrumental in strengthening our relationships with our key academic partners including the University of Brighton, Brighton and Sussex Medical School and the Blond McIndoe Research Foundation. Wide networks are critical to successful research investment and outputs, especially in the specialised fields of practice of QVH. We are seeking to build closer ties to the excellent facilities, expertise and resources available on-site at the Blond McIndoe Research Foundation and expect this relationship to develop over the coming year. The two organisations are well placed to link together into the work of specialised centres at national and even international level.

The total number of participants that were recruited to research studies approved by a research ethics committee in 2015/16 was 375, with QVH taking part in 32 studies. Our participation in research demonstrates our continued commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Participation helps our clinical staff to stay abreast of the latest treatment possibilities and enables us to deliver improved patient outcomes.

Participation in clinical audits and clinical outcome review programmes

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

During 2015/16, three national clinical audits and three clinical outcome review programmes (previously known as confidential enquiries) covered relevant health services that QVH provides.

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

Participation	✓ Yes	✗ No	**% of cases submitted**	100% Percentage	ND No data - figure unavailable as audit ongoing

Participation in national clinical audits 2015/16

National audit of non-melanoma skin cancer excision	Rheumatoid and early inflammatory arthritis	UK flap registry
✓ ND	✓ 100%	✓ ND

Participation in clinical outcome review programmes 2015/16

Gastrointestinal haemorrhage (NCEPOD*)	Sepsis (NCEPOD*)	Care of patients with mental health problems in acute general hospitals (NCEPOD*)
✓ 100%	✓ 100%	✓ 100%

* National confidential enquiry into patient outcome and death

Three national clinical audits were reviewed by QVH in 2015/16 and we intend to take the following actions to improve the quality of healthcare provided:

Rheumatoid and early inflammatory arthritis

The published report highlighted that QVH is not currently meeting the expected rheumatology services waiting times as recommended by NICE guidance. We are exploring new ways of identifying this patient cohort and freeing up non-urgent capacity to accommodate urgent referrals in a more timely manner.

Sepsis (NCEPOD)

Findings of the study were presented to the trust's joint hospital governance meeting to ensure dissemination. This work was also used to inform the trust's new sepsis policy and pathway and its activity to achieve sepsis-related CQUIN targets. Work is ongoing to ensure that we are able to recognise and treat patients with sepsis effectively.

Gastrointestinal haemorrhage (NCEPOD)

Our processes for transferring gastrointestinal patients to a neighbouring provider after attending QVH were reviewed to ensure they continue to be fit for purpose. The report was also disseminated across the trust for information.

Local clinical audit

The reports of 46 completed local clinical audits were reviewed by QVH in 2015/16. Examples of audit projects undertaken across QVH, their findings and actions taken as a result, include:

NICE clinical guideline 50 - Acutely ill adults in hospital: recognising and responding to deterioration

Overall, the audit, which was carried out in quarter 1 of 2015/16, demonstrated safe care of the acutely ill patients in the sample group. It was evident from the notes that there had been both prompt identification of these deteriorating patients and an appropriate and timely escalation of their care. This is now a rolling audit programme for QVH.

Rehabilitation care for ITU burns patients (incorporating NICE clinical guideline 83)

QVH compliance with the British Burns Association therapy guidelines for the rehabilitation of ITU burns patients (incorporating CG83) during this period of the audit (July-August 2015) was high. The few non-compliant elements of the pathway were due to poor documentation. In response, new burns therapy rehabilitation documentation has been created and introduced for all ITU and ward patients. This ensures that all ITU patients receive the same high standards of rehabilitation. The audit is now part of the local rolling audit programme. In addition, this project has also led to the initiation of two further rolling audits: an audit of rehabilitation care provided for QVH burns inpatients and an audit of multi-speciality compliance with CG83.

Pressure damage - understanding the impact of differences in care

QVH was concerned about an increase in the number of pressure ulcers seen. The audit was developed to explore whether the increase was caused by any differences in the care given to patients with areas of pressure damage of grade 2 or above. The audit found that in some cases care needed to be more individualised and more patient education was required. As a result we have introduced a new assessment tool and patient information leaflet.

Prevention of perioperative hypothermia

Perioperative hypothermia (<36°C) is associated with increased morbidity and mortality (wound infections, transfusion, increased oxygen consumption and shivering). It is therefore imperative that inadvertent hypothermia is prevented in the perioperative period. NICE CG65 recommends that less than 5% of patients undergoing surgery should be less than 36°C at recovery. The audit demonstrated that only 1.6% of patients in the audit experienced hypothermia. It recommended that we continue warming patients intra-operatively using current methods such as heat and moisture exchange filter, warming mattress, and Bair huggers as appropriate. Further work was undertaken to ensure staff are aware of the time interval required for recording temperature when patients are admitted to recovery.

Balance and bone group patient satisfaction

The project found that all of the patients audited felt the course was beneficial, based at the right level for them, and that the questionnaires used were easy to understand. The service will continue the course in this current format and explore the possibility of providing talks to patients on anxiety as part of confidence-building.

Women's health audit

The audit was carried out between February 2014 and January 2015 but the results were presented during 2015/16. The purpose of the women's health audit was to monitor the number of referrals to the women's health physiotherapy service and to explore which conditions are being treated most frequently and how effectively we are treating them. A satisfaction survey is also conducted to see how happy patients are with their treatment and the service they receive. The service sees approximately 100 patients a year and discharges a similar number. The service primarily sees patients for stress incontinence and prolapse. MYMOP (Measure Yourself Medical Outcome Profile) and Quality of Life scores are used as outcome measures and both show that the treatments provided are effective, with 71% of patients reporting a positive change in symptoms by the end of their treatment. Furthermore, in 2015, 100% of patients said they would recommend the service to family and friends.

Compliance with the NPSA alert for conscious sedation with midazolam

The audit found that small quantities of flumazenil (a drug to reverse the effects of anaesthesia, which can also be used to treat an overdose of midazolam) are used across the hospital by appropriately trained staff, in line with the trust's policy. QVH was found to be compliant with the NPSA guidance but it was difficult to ascertain exactly which purpose the flumazenil was used for. Findings were discussed at the medicines management optimisation group and further work will be undertaken to ensure a process is in place to document reasons for use.

Effectiveness and benefit of the multiple sclerosis exercise group

Patients with MS attended an exercise group for six weeks. Therapy outcome measures were used as a standardised tool to measure clinical outcomes. They found a 13.7% improvement in participation with exercise; 16.2% improvement in activity; and 12.7% improvement in wellbeing. There was no change in impairment, suggesting maintenance, which is positive as the condition is chronic and progressive. The combined score of all four outcomes shows a positive improvement of 10.65%. These results demonstrate that the exercise class has a significantly positive clinical impact for these patients.

GP direct access to lumbar spine MRI

This audit to assess whether the pathway was effective found that direct access MRI delivered a better service for patients, as stated by 73% of the GP-referrers in the study. In addition, it was found that lumber MRI cannot be analysed in isolation and must be incorporated into a global assessment of the patient that takes into account patient history and clinical examination.

Pressure garment fabric trial

After trialling a new fabric with increased quality (and in various colours), audit results found that 89% of patients liked having a choice of colour, allowing them to individualise their garment. More significantly, 53% of patients found a difference in the tension of the fabric and 78% of these patients found it to be tighter, resulting in improved clinical outcomes. Clinicians noted that the fabric was true to pattern and shape after 12 weeks. The new quality was an essential improvement to stock in beige and the most popular blue, pink and purple would be offered for resupplies.

Documentation of patient consent and clinical rationale for transfusion

National guidelines recommend that: valid consent for blood transfusion should be obtained from the patient and documented in the clinical record; the reason for transfusion should be clearly documented; and patients should be made aware that they have had a transfusion. The audit found that documented evidence for these recommendations requires improvement. Further work will be undertaken to amend the format of the blood prescription chart, to improve patient information and raise staff awareness.

Commissioning for Quality and Innovation payment framework

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

QVH income in 2015/16 was not conditional on achieving any CQUIN goals because the trust opted for a tariff system that did not include any payment for quality initiatives. However, despite not having this extra funding, QVH decided to drive a number of quality improvement initiatives of its own to ensure the concept of annual quality improvement cycles remained embedded within the organisation and that improvements in patient care would continue to be delivered by clinical staff.

The quality initiatives were:

Identification and treatment of acute kidney injury
An electronic alert for patients who may be developing acute kidney injury (AKI) at QVH was developed and implemented in conjunction with a partner acute hospital trust. A review of AKI cases at QVH was carried out against specific audit measures as recommended by the Kent, Surrey and Sussex Academic Health Science Network. In addition, online teaching is being rolled out to staff, which includes the identification of high risk patients and fluid therapy prescribing.

Identification and treatment of sepsis
A new policy for the early identification and management of patients with sepsis has been introduced, with an accompanying treatment pathway. Work has been undertaken to increase staff awareness of the policy and the importance of sepsis screening and early management.

'Human factors' training
Human factors in healthcare is about applying an understanding of the effects of teamwork, tasks, equipment, the working environment and culture on human behaviour to enhance clinical performance. A programme of human factors training has been made available to all staff across the trust.

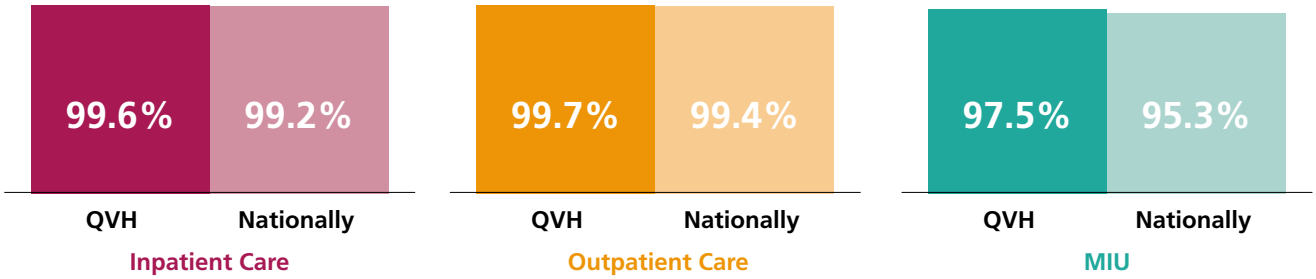
Implementation of the dementia strategy
A trust-wide dementia strategy has been developed with objectives to ensure that people with memory impairments are cared for with dignity and compassion and given any extra support they need. It will be audited during the coming year.

"QVH decided to drive a number of quality improvement initiatives of its own to ensure the concept of annual quality improvement cycles remained embedded within the organisation."

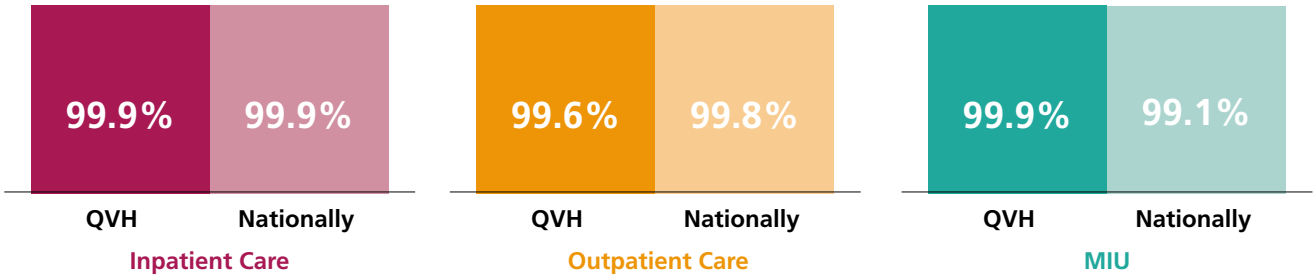
Hospital Episode Statistics

QVH submitted records during 2015/16 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

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



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



Source: The figures are aggregates of the QVH entries taken directly from the SUS data quality dashboard provider view, based on the provisional April 2015 - January 2016 SUS data at the month 10 inclusion date.

Information governance toolkit

Information governance ensures that information held about patients and staff is kept safe and secure. The information governance toolkit is the way in which we demonstrate our compliance with information governance standards. The trust's information governance group oversees the annual submission.

QVH's information governance toolkit overall score for 2015/16 was 77% and graded 'satisfactory'.

During 2015/16, an internal audit of information governance gave the trust an outcome of 'substantial' assurance but also provided a series of recommendations for implementation which will support and improve performance.

All staff and volunteers are mandated to undertake information governance training on an annual basis. During 2015/16 there has been a targeted action plan to increase awareness of responsibilities in relation to safeguarding confidentiality, protecting data and preserving information security.

The trust did not report any significant personal data breaches in 2015/16 and all incidents were graded as causing minor level or no harm to patients. Incidents which do occur are fully investigated and practice is changed where appropriate.

Payment by Results and clinical coding

QVH was subject to the clinical coding audit during the reporting period by an external coding consultancy. Compliance rates reported in the latest published audit for that period for the clinical coding of diagnoses and treatment was:

- Primary diagnoses 95%
- Secondary diagnoses 93.47%
- Primary procedures 94.97%
- Secondary procedures 96.75%.

The results should not be extrapolated further than the actual sample audited.

The following services were reviewed within the sample:

- Children's and adolescent service
- Dentistry and orthodontics
- Ear, nose and throat
- Head and neck cancer services
- Oral and maxillofacial surgery
- Hands
- Ophthalmology
- Plastic surgery
- Sleep medicine
- Breast surgery
- Skin cancer services
- Vascular surgery.

Improving data quality

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

Over the coming year, QVH will take the following actions to improve data quality:

- The data quality improvement group will focus on a range of metrics to enhance data accuracy and completeness through the proactive identification of issues in data quality and improved training penetration to reduce recurrent issues.
- Data warehouse technologies will be installed for information storage and analysis.
- Improved data aggregation and analysis will be implemented to support faster analysis turnaround and the rapid resolution of observed anomalies.
- Data quality reporting and performance management will be enhanced and refined.

Registration with the Care Quality Commission

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

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

The CQC has not taken enforcement action against QVH during 2015/16 and QVH has not participated in any special reviews or investigations by the CQC during this reporting period.

The CQC conducted a routine announced inspection of the trust on 11-12 November 2015. A team of 35 inspectors visited the QVH registered hospital site and conducted a further unannounced spot check on 23 November 2015.

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

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

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

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

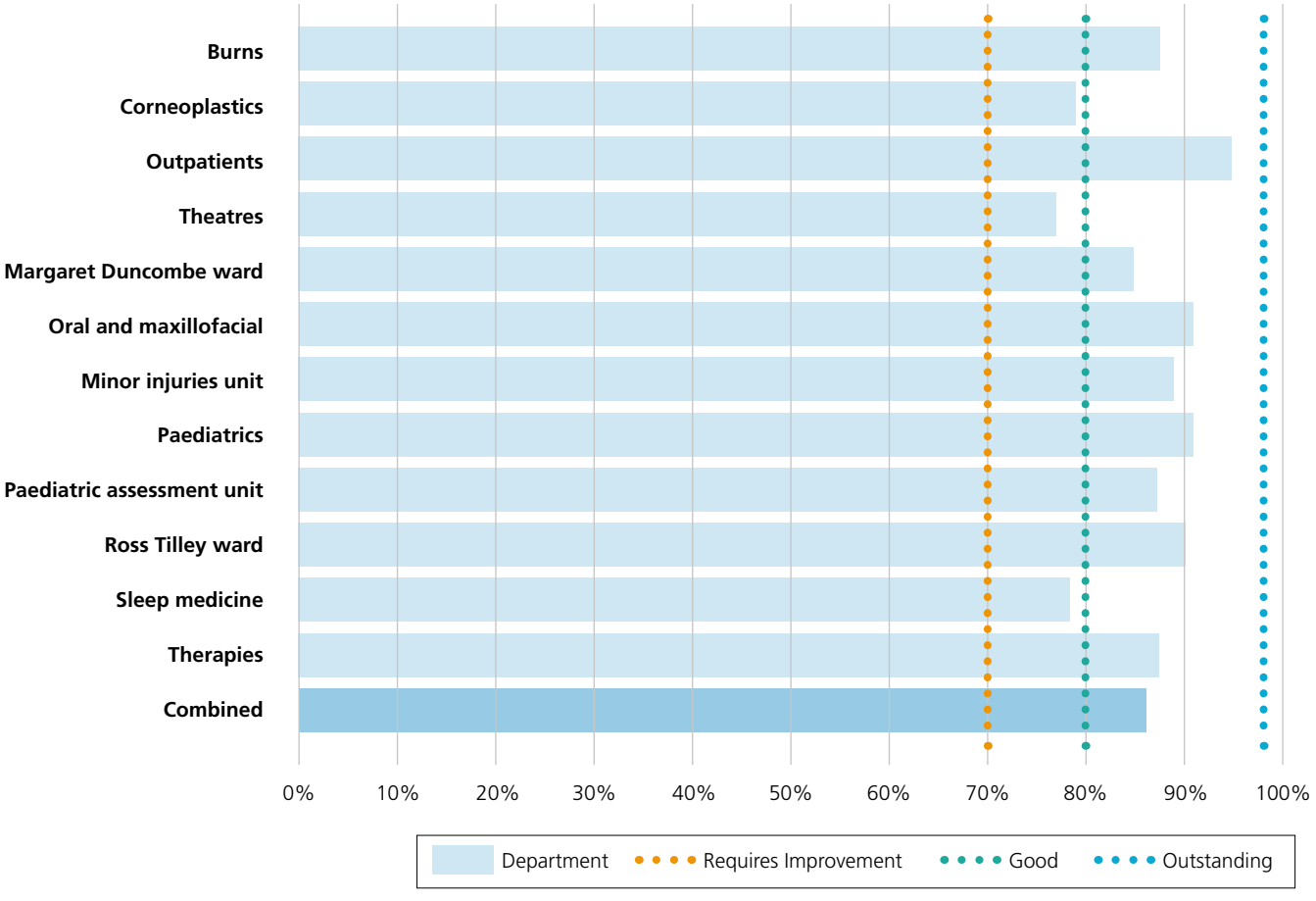
*The CQC inspectors were unable to collect sufficient evidence to rate the caring domain in critical care because only three patients were in the unit at the time of the inspection and two could not be interviewed for clinical reasons.

Compliance in Practice

Compliance in Practice is an improvement initiative undertaken across the trust to measure ongoing compliance with the CQC's essential standards.

To support ongoing compliance against CQC essential standards, QVH re-launched a programme of continuous improvement visits across the site from January 2016. This work builds on the trust's preparations for the CQC inspection and helps to identify weaker areas of practice while ensuring standards of care and treatment are maintained. These visits are undertaken by a variety of staff, public governors and both clinical and non-clinical stakeholders.

Compliance in Practice ratings, quarter 4 2015/16



National core quality indicators

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

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

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

Mortality

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

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

In-hospital surgical mortality

2013/14	2014/15	2015/16
0.01%	0.02%	0.03%

Source: QVH information system

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

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

Readmission within 28 days of discharge

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

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

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

Work is underway to explore whether there are issues around weekend activity and whether operations or discharges over weekends have a higher than expected complication rate. Clinical indicators such as readmissions provide broad indicators of the quality of care and enable us to examine trends over time and identify any areas requiring extra scrutiny.

Emergency readmissions with 28 days

	Discharges		Readmissions		28 days readmission rate	
	14/15	15/16	14/15	15/16	14/15	15/16
Under 16	2,164	2,238	8	21	0.37	0.94
16 +	16,174	17,049	230	175	1.42	1.03
Total	**18,338**	**19,287**	**238**	**196**	**1.30**	**1.02**

Source: QVH information system

National core quality indicators

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

Work is underway to explore whether there are issues around weekend activity and whether operations or discharges over weekends have a higher than expected complication rate. Clinical indicators such as readmissions provide broad indicators of the quality of care and enable us to examine trends over time and identify any areas requiring extra scrutiny.

Infection control - hand hygiene compliance

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

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

Hand hygiene (washing or alcohol gel use)

Target	2013/14	Target	2014/15
95%	99%	98.4%	99.1%

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

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

Infection control – Clostridium difficile cases

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

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

	2012/13	2013/14	2014/15	2015/16
Trust attributed cases	0	1	1	1
Total bed-days	18,790	18,362	15,143	Not published, expected July 2016
Rate per 100,000 bed-days for specimens taken from patients aged 2 years and over (trust attributed cases)	18,338	19,287	238	
National average rate for acute specialist trusts	17.4	14.7	15.1	
Best performing trust	0	0	0	
Worse performing trust	31.2	37.1	62.2	

Source: Health and Social Care Information Centre data

QVH continues to maintain its low infection rate through surveillance supported by robust policies and procedures linked to evidence-based practice and NICE guidance. Infection rates are routinely monitored through the trust's infection prevention and control group and quality and governance committee

Reporting of patient safety incidents

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

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

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

Patient safety incidents

	2013/14		2014/15		2015/16	
	01/04/13-30/09/13	01/10/13-31/03/14	01/04/14-30/09/14	01/10/14-31/03/15	01/04/15-30/09/15	01/10/15-31/03/16
Total reported patient safety incidents	493	477	476	470		
Incident reporting rate per 1,000 spells	60	54	52	52		
Incidents causing severe harm or death	0	0	1	0		
Percentage of incidents causing severe harm or death	0%	0%	0.2%	0%		
Acute specialist trust benchmarks	**01/04/2013-30/09/2013** (per 100 admissions)	**01/10/2013-31/03/2014** (per 100 admissions)	**01/04/2014-30/09/2014** (per 100 admissions)	**01/10/2014-31/03/2015** (per 100 admissions)		
Lowest incident reporting rate	3.69	4.72	17.63	16.33		
Highest incident reporting rate	27.88	32.88	94.84	108.54	Data expected September 2016	
Specialist trust average total (median)	n=636	n=750	n=745	n=849		
Lowest % incidents causing severe harm	0%	0%	0%	0%		
Lowest % incidents causing death	0%	0%	0%	0%		
Highest % incidents causing severe harm	2.3%	3.6%	3.8%	3.9%		
Highest % incidents causing death	0.8%	0.5%	1.1%	0.9%		
Average % of incidents causing severe harm	0.4%	0.4%	0.4%	0.3%		
Average % of incidents causing death	0.1%	0.1%	0.1%	0.1%		

Source: QVH data from Datix and benchmarking data from NRLS data workbooks on 23/02/2016

QVH encourages all healthcare professionals to report incidents as soon as they occur as we believe that this reflects a positive safety culture. Work has commenced on reducing incident investigation timeframes during 2016/17. This will help to improve the reporting of patient safety incidents to NRLS and NHS England and the identification of key learning aspects for timely dissemination. This is also one of the areas included in our Sign up to Safety pledges which can be viewed on our website, and is one of our local CQUINS for 2016/17.

WHO safe surgery checklist

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

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

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

Use of the WHO Safe Surgery checklist

	2013/14	2014/15	2015/16
Sign in	98%	100%	99.58%
Time out	96%	100%	98.05%
Sign out	82%	100%	92.88%
	Target 100%		

Source: Monthly internal audit

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

The WHO checklist was a 2014/15 CQUIN which was achieved. The original audit process has continued to ensure that we are able to maintain compliance. We continually review the results and actions for improvement which have included 'human factors' training during 2016.

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

Venous thromboembolism

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

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

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

VTE assessment rate

	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16
QVH	100%	100%	100%	100%	93.9%	97.5%
National average	96.1%	96.2%	96%	96%	96%	95.9%
National average specialist trusts	**97.4%**	**97.3%**	**97.4%**	**98%**	**98.7%**	**97.7%**
Best performing specialist trust	**99.5%**	**99.1%**	**99.9%**	**100%**	**99.9%**	**100%**
Worst performing specialist trust	**94.6%**	**93.3%**	**94.3%**	**95%**	**95.3%**	**95.1%**

Source: QVH information system

QVH has revised its policies in accordance with NICE clinical guideline 92 and is committed to ensuring that those patients undergoing surgery are risk assessed and the necessary precautions are provided, including compression stockings and low molecular weight heparin.

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

We continuously strive to minimise VTE as one of the most common causes of largely preventable post-operative morbidity and mortality.

Pressure ulcers

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

- QVH has a robust process for collating the incidence of pressure ulcers
- A retrospective 'deep dive' and audit have been completed to determine incidence
- The 'Purpose T' tool has been introduced to replace the existing tool to enhance staff awareness and education around pressure damage and teaching sessions have been set up for all areas
- QVH has also trialled and purchased new pressure aiding equipment including hybrid mattresses, seat and head pads and pressure relieving gel pads for long surgical cases.

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

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

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

A pressure ulcer 'deep dive' audit has been undertaken into the care provided at QVH and each pressure ulcer has a full root cause analysis undertaken. Further multidisciplinary training has been undertaken and a new pressure ulcer investigation tool was rolled out in 2015/16.

The majority of pressure ulcers were found to be unavoidable due to the patient's condition, but where learning was identified it has been rolled out in all clinical areas.

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

Same sex accommodation

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

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

Failure to deliver single sex accommodation (occasions)

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

QVH is committed to providing every patient with same sex accommodation to ensure that we safeguard their privacy and dignity when they are often at their most vulnerable. We have maintained segregated accommodation during 2015/16 through the use of single rooms and the appropriate planning of patient admissions.

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

NHS friends and family test – patients

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

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

NHS friends and family test scores (from patients)

	Minor injuries unit		Acute inpatients		Outpatients	
	2014/15	2015/16	2014/15	2015/16	2014/15	2015/16
Percentage extremely likely/likely to recommend	94%	94%	99%	99%	98%	94%
Percentage unlikely/extremely unlikely to recommend	2%	3%	0%	0%	1%	2%
Response rate	27%	25%	43%	51%	7%	18%

Source: QVH information system

QVH continually strives to ensure that patients receive the best care and patient experience while attending our services. Comments received electronically are reviewed on a daily basis so that we are able to respond to potential issues in a timely manner. Friends and family test response rates are amongst the highest in the south of England.

We have a very engaged patient experience manager who is accessible and visible to patients. Our current engagement strategy will continue into 2016/17 and further work is being undertaken to break down responses and comments into weekday and weekend feedback to help inform our continued implementation of seven-day services at QVH. Patient feedback is also used to help us tailor our friends and family test collection methods to help capture the most responses.

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

Complaints

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

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

Complaints per 1,000 spells

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

Source: Continuous internal audit

QVH endeavours to respond to all patient and service user complaints in a timely and satisfactory manner to ensure that their issues can be resolved as effectively as possible. We are proud of our year-on-year reduction in formal complaints but continue to use them as an important mechanism to assess the quality of services provided and to understand where improvements can be made.

During 2015/16, only one compliant was referred to the Parliamentary Health Service Ombudsman, and was resolved to the satisfaction of the patient.

NHS friends and family test – staff

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

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

NHS friends and family test scores (from staff)

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

Source: www.nhsstaffsurveys.com

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

Staff experiencing harassment, bullying or abuse

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

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

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

	Never	1-2	3-5	6-10	10+
QVH	82.4%	13.2%	2.5%	1.1%	0.7%
Average (median) for all trusts	80.4%	13.6%	3.6%	1.1%	1.3%

Source: NHS staff survey

QVH has recently developed a new dignity and respect at work policy and procedure which is used specifically for cases of harassment and bullying. In addition, QVH has a clear policy and process for managing and dealing with concerns (whistleblowing) raised by staff. Over the next 12 months, we will deliver training for all staff on the new policies and will provide managers with further development on how to manage allegations of bullying and harassment.

Equal opportunities for career progression

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

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

Percentage of staff reporting equal opportunities for career progression and promotion

	Yes	No	Don't know
QVH	61.8%	7.5%	30.7%
Average (median) for all trusts	59.2%	11.0%	29.8%

Source: NHS staff survey

QVH currently delivers high levels of statutory and mandatory training. Over the next 12 months we will focus on delivering training that is aimed at supporting personal development including providing staff with the skills to fully realise their potential and take up progression and promotion opportunities. In addition, we will be encouraging recruiting managers to advertise secondment opportunities that give staff the chance to demonstrate that they have the skills required to undertake more senior job roles.

"Over the next 12 months we will focus on delivering training that is aimed at supporting personal development including providing staff with the skills to fully realise their potential and take up progression and promotion opportunities."

Monitor national priority indicators

Monitor is the independent regulator responsible for authorising, monitoring and regulating NHS foundation trusts.

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

QVH's 2015/16 performance against these indicators was:

			Performance			Quarterly trend			
		National priority indicator	Target	Annual	RAG	Q1	Q2	Q3	Q4
Safety	**Infection control**	Clostridium difficile acquisitions	De-minimis 15	1		0	0	0	1
Experience	**Referral to treatment times**	Percentage of admitted patients treated within 18 weeks April – September	90%	91.42%		92.60%	90.53%		
		Percentage of non- admitted patients treated within 18 weeks April – September	95%	95.37%		96.20%	94.71%		
		Percentage of incomplete pathways less than 18 weeks October – March	92%	94.42%				93.22%	93.31%
	MIU access	Attendees completing treatments and leaving within 4 hours in minor injuries unit	95%	95.05%		99.37%	98.97%	98.82%	99.01%
Effectiveness	**Cancer access – initial appointments**	Urgent cancer referral seen within 2 weeks wait	93%	95.6%		94.80%	94.70%	95.90%	95.4%
	Cancer access – initial treatments	Percentage of cancer patients treated within 62 days of urgent GP referral	85%	82.9%		85.40%	85%	75.90%	86.6%
		Percentage of patients treated within 62 days from screening referral Screening service not offered at QVH, all patients are on a shared pathway with other providers	85%	57.1%		57.10%	66.70%	100%	33.3%
		Percentage of treatment started within 31 days from decision to treat (first treatment)	96%	95.1%		98.50%	98.80%	95.40%	87.5%
		Percentage of treatment started within 31 days from decision to treat (subsequent treatment)	94%	96.4%		97.80%	97.30%	96.10%	93.5%

Source: QVH information system

Monitor national priority indicators

Cancer patients treated within 62 days

The target for all patients to receive their first definitive treatment within 62 days of an urgent GP referral for suspected cancer was met in three of the four quarters of 2015/16. QVH underperformed against the target in quarter 3, primarily due to late referrals from other trusts. We have made a number of improvements, including: regular liaison with off-site management teams to improve processes for joint pathways; discussions with individual trusts when an immediate breach has occurred due to the unavailability of a visiting consultant or any other reason; raising concerns with other trusts and asking them to review systems; and closer liaison with health records managers so that the cancer administration team have full access to all oncology referrals.

18 weeks referral to treatment times

These measures relate to patients who are waiting to be treated. They may have been seen, but are awaiting a first definitive treatment. National and local NHS standards require patients to be admitted for surgery or scheduled (elective) services within 18 weeks of referral by their GP. We are pleased to report that QVH has consistently achieved the open pathway target of 92% every month throughout 2015/16.

Operations cancelled by the hospital for non-clinical reasons

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

	How data is collected	Target	2013/14	2014/15	2015/16
Cancer - 62 day wait from referral to first definitive treatment	Data collected monthly and reported quarterly; performance includes shared care with other providers	85%	89.3%	87.0%	82.91%
18 weeks - incomplete pathways	Data collected from monthly snapshots	92%	93.8%	93.5%	94.3%
MIU - patients leaving without being seen	Data collected from PAS in the minor injuries unit	5%	1.3%	1.9%	2.4%
Operations cancelled on the day of surgery for non-clinical reasons and not rebooked within 28 days	Data collected from PAS and theatre systems	0	Data not collected for the period	3	4
Urgent operations cancelled for non-clinical reasons for a second or subsequent time	Data collected from PAS and theatre systems	0	Data not collected for the period	3	3

Clinical effectiveness indicators

In 2015/16 QVH's clinical specialities continued to be amongst the most experienced and effective in the world.

Head and neck
Survival after 30 days

126 Major cancer cases

98.4% QVH success rate
98.3% National average

Orthodontics
Improvement in tooth position

14,646 Orthodontic procedures

98% QVH success rate
70% National benchmark

Breasts
Treatment following cancer

259 Breast reconstructions

99.6% QVH success rate
98% National average success rate

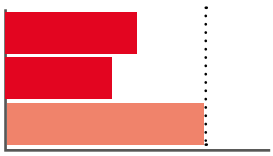
Eyes
Achieved better than 6/12 vision

1,252 Cataract procedures

100% QVH success rate
96% National benchmark

Burns
Average burn wound healing time

1,094 Adult
934 Paediatric



14 days adult
11 days paediatric
‹ 21 days established benchmark

Skin cancer
Melanomas completely removed

248 Melanomas removed

97% QVH complete excision rate
75% National benchmark

Hands
Improvement in function after surgery

1,881 Elective procedures

34 points QVH average
7 points benchmark

Anaesthetics

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

Percentage of patients requiring no recovery room intervention following anaesthesia

2013/14	2014/15	2015/16
88%	88%	88%

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.

Recovery room interventions are a necessary and expected part of perioperative care for a number of patients. A high number of recovery interventions could reflect patients with pre-existing complications, or complications of surgery requiring treatment in the recovery area. They could also reflect variation in anaesthetic care, therefore interventions are recorded for all consultants to look for outlying data requiring further explanation. An intervention-free recovery rate of 88% overall with no outlying data provides assurance of the quality of care. There is no national benchmark for this figure which we collect for internal assurance.

Breast surgery

QVH is the major regional centre for complex, microvascular breast reconstruction either at the same time as a mastectomy for breast cancer (immediate) or after all treatment has been completed (delayed). We are increasingly being asked to carry out reconstruction on the same day as removing both breasts for patients who have a genetic predisposition to breast cancer (BRACA gene). This is likely to increase further 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 extend this to others.

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

Breast reconstruction after mastectomy using free tissue transfer - flap survival

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

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

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

Hand surgery

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

The department includes five hand consultants and a comprehensive hand therapy department 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 South East England and South East London and covers all aspects of hand and upper extremity trauma. It is catered for by a 24-hour trauma service with access to two dedicated trauma theatres for inpatient and day-case procedures.

	2013	2014	2015	Jan - Mar 2016
Total elective hand procedures	1422	1893	1881	431
Total trauma cases	2384	3084	2972	680
Total new outpatient appointments	4380	5897	5779	919

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

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

"A reduction of seven points or more in the QuickDASH score is a material improvement in the ability to use the hand. At QVH we achieve this and more and measuring outcomes enables us to validate and improve the overall quality of the service"

QuickDASH

QuickDASH trauma scores before and after treatment

	2014			2015		
	Before	After	Difference	Before	After	Difference
Bone	44.66	5.15	-39.51	41.08	7.4	-33.68
Muscle and tendon	49.27	5.07	-44.2	45.75	5.86	-39.89
Nerve	39.95	3.6	-36.35	46.67	9.82	-36.85
Neural vascular	38.77	6.96	-31.81	36.36	7.85	-28.51
Skin	38.35	5.68	-32.67	36.25	6.99	-29.26
Ligament	36.42	7.95	-28.47	32.77	3.57	-29.2
Multiple trauma	55.75	7.32	-48.43	54.16	6.43	-47.73
Minor trauma	22.69	4.3	-18.39	37.79	7.65	-30.14
Miscellaneous	33.21	6.47	-26.74	32.57	3.78	-28.79
Average	**39.9**	**5.83**	**-34.06**	**40.38**	**6.59**	**-33.78**

QuickDASH elective scores before and after treatment

	2014			2015		
	Before	After	Difference	Before	After	Difference
Tendinopathy	28.28	3.79	-24.49	35.17	13.53	-21.64
Trapeziectomy	44.25	12.32	-31.93	50.18	19.57	-30.61
Fusion (PIP/DIP)	24.97	1.82	-23.15	36.36	19.7	-16.66
Fusion (thumb)	49.99	9.84	-40.15	47.72	9.09	-38.63
CTD and CTS	39.77	4.83	-34.94	37.37	13.87	-23.5
Cubital tunnel	50	19.32	-30.68	40.34	3.41	-36.93
Joint release and tenolysis	37.95	17.5	-20.45	28.28	10.6	-17.68
OA and RA conservative mx	32.33	14.35	-17.98	33.39	23.97	-9.42
Joint replacement (PIP/DIP)	40.05	28.69	-11.36	30.5	11.36	-19.14
Joint replacement (MCP)	48.86	15.91	-32.95	38.82	23.86	-14.96
Xiapex	12.52	4.04	-8.48	14.3	5.22	-9.08
Fasciectomy	23.83	4.96	-18.87	20.4	4.81	-15.59
Dermofasciectomy	23.58	5.24	-18.34	26.29	6.68	-19.61
Major elective (brunelli, etc)	48.56	12.27	-36.29	42.34	17.59	-24.75
Minor elective (trigger, etc)	29.99	6.82	-23.17	28	9.53	-18.47
Average	**35.66**	**10.78**	**-24.88**	**33.96**	**12.85**	**-21.11**

Burns service

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

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

In 2015, the QVH burns service accepted:

- 1,094 adult (>16 years of age) new referrals
  - of which 232 needed inpatient care
  - with 34 requiring intensive care in QVH's critical care unit.
- 934 paediatric (<16 years of age) new referrals
  - of which 68 required inpatient care.

QVH's paediatric ward provides up to high dependency care. Children who have sustained larger burns or require ITU are referred to paediatric burns services within the LSEBN that have the appropriate facilities.

In 2015, five adult burns patients who had sustained major burn injuries died. This equates to an adult burns inpatient mortality rate of 2%. There were no paediatric deaths. All patient deaths are discussed at weekly governance meetings so that any learning points can be identified. If further review is required, the patient's case is discussed at a joint hospital governance meeting. In addition, all burns mortality cases are peer reviewed at the annual LSEBN audit meeting with any 'outlier' cases taken to the national burns mortality meeting. None of the five deaths at QVH in 2015 were considered to be outliers. Sadly, all the patients had sustained injuries which, given their age and / or co-existing medical conditions, it was not possible to survive.

Key burns performance indicators are recorded and analysed through QVH's active participation in the international burns injury database (iBID) programme. This compares QVH's performance with that of all other English burns services in relation to set quality indicators. Overall in 2015, QVH achieved better than the national average for the six valid dashboard indicators for both adult and paediatric burns care.

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

Burns healing in less than 21 days are less likely to be associated with poor long-term scars. Evidence is now emerging that patients over the age of 65 have similar outcomes even if their healing time is extended to 31 days. However, a shorter burn healing time may reflect better quality of care through dressings, surgery and prevention of infection.

Burns healing times

	Target	2013	2014	2015
Adults 65 years and under wound healing within 21 days	80%	62%	64%	70.40%
Adults >65 years wound healing within 21 days	70%	50%	59%	71.60%
Average time for adult burn wound healing (median)	<21 days	17 days	16 days	14 days
Paediatric (<16 years) wound healing within 21 days	<21 days	88%	88%	86%
Average time for paediatric burn wound healing (median)	<21 days	16 days	10 days	11 days

Head and neck

QVH is the regional tertiary referral centre for major cancer and reconstruction of the head and neck. Our head and neck services are recognised, regionally and nationally, for the specialist expertise offered by our large consultant body which continues to grow, with the addition of a maxillofacial consultant and two ENT consultants in 2015. 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.

Total number of major head and neck cancer procedures

2013	2014	2015
65	106	126

The total number of major head and neck patients treated in 2015 was 126, with a 30-day survival rate of 98.4%. This compares with a national benchmark from the DAHNO database of 98.3% for 2014. The 2015 survival rate is pending confirmation by the new national HANA database, which is expected in late 2016.

We endeavour to give the highest quality of patient care and continually strive to improve in line with evidence-based best practice. Multidisciplinary improvements in 2015/16 included trust-wide tracheostomy training in line with NCEPOD recommendations given by surgeons, anaesthetists, physiotherapists, speech and language therapists and specialist nurses. In addition, the increasing number of laryngectomy procedures has allowed us to further extend our training using the same approach.

Enhanced recovery for patients undergoing major head and neck cancer surgery was developed by a multidisciplinary team and began in January 2016. It ensures we involve our patients in the care given by the multidisciplinary and aims to optimise outcomes and reduce lengths of stay.

During 2015/16 we worked towards the implementation of sentinel node biopsy for early oral cancer requiring surgical management, supported by NICE clinical guideline NG14 published in February 2016. We anticipate commencing this service in 2016. Two members of the QVH head and neck consultant body were involved in formulation of these guidelines and are now members of the NICE quality assurance implementation group.

In order to deliver complete head and neck care, including palliative treatments to enhance quality of life, we are well advanced in developing our patient pathways and staff training to enable us to commence electrochemotherapy (ECT) treatment to skin nodules of the head and neck. Currently, patients from Kent, Surrey and Sussex can only access this care in central London and we aim to bring it closer to the patient's home.

We also use audit to enhance best practice and this year introduced a new consent form for major head and neck surgery as the result of an audit. The consent process is complex and we aimed to ensure that major risks and benefits were both discussed in detail and also fully documented for the benefit of patients and the clinicians caring for them. We showed a significant improvement in documentation of consent, with indicator risks comprehensively recorded.

QVH drove a major national audit which found that significant numbers of other head and neck units could benefit from the introduction of a similar consent process and form. This nationwide development is supported by the British Association of Maxillofacial Surgeons.

"We endeavour to give the highest quality of patient care and continually strive to improve in line with evidence-based best practice."

Maxillofacial service - orthognathic treatment

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

Patient satisfaction with orthognathic treatment

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

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

Orthodontics

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

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

The PAR provides an objective measure of the improvement gained by orthodontic treatment. The higher the pre-treatment PAR score, the poorer the bite or occlusion; a fall in the PAR score reflects improvement in the patient's condition. Improvement can be classified into: 'greatly improved', 'improved' and 'worse/no different'. On both scales, QVH scores well. In 2014/15, 98% of our patients were assessed as 'greatly improved' or 'improved'. This is reflected in the table below.

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

	2012/13	2013/14	2014/15*
PAR score	95%	95%	98%

*Data is produced one year in arrears

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

Orthodontics continued

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

In 2015/16, 181 patients completed the satisfaction questionnaire. The significant majority (86%) were completely satisfied with the result of their treatment and the remaining 12% were fairly satisfied. Furthermore, 98% were happy that their teeth were as straight as they would have hoped.

In addition, 94% of patients were happy with the appearance of their teeth after treatment; 86% reported improved self-confidence; 68% reported an improved ability to keep teeth clean; 62% reported improved ability to chew; and 29% reported improved speech.

A total of 97% of patients felt that they were given sufficient information regarding their proposed treatment; 98% of patients said that they were glad they undertook their course of treatment; and 92% would recommend a similar course of treatment to a friend.

Mandibular advancement splint

Mandibular advancement splint

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

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

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

	2014/15	2015/16
Patients wearing the splint at least four nights a week	88%	82%
Patients reporting snoring less or not at all since receiving the splint	50%	79%
Patients suffering from aching teeth and jaws (a common and warned about risk factor of this treatment)	69%	69%
Patients reporting their apnoea has been resolved (usually reported by sleep partners)	80%	83%
Patients reporting their sleep quality is better than before	78%	82%
Patients reporting reduced daytime sleepiness	78%	70%
Patients reporting improved general wellbeing	92%	96%

Overall, the service found an 83% resolution in apnoeic symptoms, which is in line with the published literature.

The questionnaire is currently undergoing some format updates following patient feedback. A digital kiosk has been introduced in the orthodontics department so that patients can complete the MAS questionnaire with ease. A patient information leaflet has also been developed and has received positive feedback.

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.

Complete excision rates in basal cell carcinoma

Target	2013	2014	2015
100%	92.5%	94.1%	96.8%

Basal cell carcinoma (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. In 2015/16, 1,901 BCCs were removed at QVH.

Complete excision rates in malignant melanoma

Target	2013	2014	2015
100% 75% NICE guidance	92.5%	94.1%	96.8%

Melanomas are excised with margins of healthy tissue around them, depending on the type, size and spread of tumour. These margins are set by national and local guidelines and each case is discussed by a multidisciplinary team. Total excision may not be possible because of the health of the patient or the size, position or spread of the tumour, and the team may recommend incomplete excision. In 2015/16, 248 melanomas were removed at QVH.

Corneoplastic and oculoplastic surgery

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

The team also 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.

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

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

In future, the corneoplastic unit will provide an optimised intraocular lens (IOL) power calculation to all patients undergoing cataract surgery. This will enhance visual outcomes and the predictability of refractive outcomes of cataract surgery. Additionally, cataract surgery is customised to fit the specific clinical needs of individual patients. This involves various measures to correct a patient's own refractive error including the use of special custom-made intraocular lens implants. This ultimate goal is to provide patients with an increased quality of vision in a way that also meets their individual needs. The effectiveness of this method will be audited as part of ongoing clinical review.

Sleep disorder centre

The sleep disorder centre was established in 1992 and provides a comprehensive service in sleep medicine for the south east of England. It employs 25 staff, including three consultant physicians and 12 technicians, supported by administrative staff and secretaries. The centre diagnoses and treats all sleep disorders across the south east of England but breathing disturbances during sleep constitute the largest part of referrals.

The centre is one of only a few in the UK with on-site 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 as well as a psychotherapy team for CBT treatment of insomnia.

The centre exceeds compliance with 18 week referral to treatment times with an average compliance rate of 99.11% for 2015/16.

The service received over 2,000 new referrals in 2015/16 and performed 1,656 overnight inpatient diagnostic and treatment studies as well as 475 daytime treatment admissions. Consultants and technicians conducted over 8,000 care episodes either as outpatient or telephone clinic appointments with patients.

NHS friends and family tests scores reveal that 97% of patients are extremely likely or likely to recommend the sleep disorder centre for care.

Diagnostic imaging

The diagnostic imaging department provides general radiography, fluoroscopy, ultrasound and cone beam computed tomography services on site. MRI is supplied on site two days each week by a third party provider. We run a diagnostic and therapeutic sialography service once a month. We outsource our CT scanning requirements to neighbouring trusts and private providers.

Our diagnostic imaging services support the outpatient and MIU departments at QVH and also provide important direct access to imaging for the local GP community.

The imaging department is a recognised AQP provider for ultrasound services by the Crawley and Mid Sussex and Horsham CCGs. In November 2015, we partnered with Sussex Community NHS Foundation Trust to provide management and clinical support for their diagnostic imaging departments in the High Weald Lewes and Havens area.

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

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

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

	Measurement	2014/15	2015/16
Report turnaround time	Percentage of CT, MRI, ultrasound and plain film reported within 48 hours	52%	85%
Diagnostic waiting times	Number of patients waiting more than 6 weeks for an appointment as reported in DM01 return	8	13
Diagnostic waiting time performance	Percentage of patients referred for CT, MRI or non-obstetric ultrasound seen within 6 weeks of referral	99.56%	99.60%

Therapies

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

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

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

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

- Patient specific functional score (PSFS) - an outcome measure which assists in identifying activities impaired by illness or injury. Our target is for a change of 3 points or more.
- QuickDASH - measures physical function and symptoms in people with musculoskeletal disorders of the upper limb. A change exceeding 7 points is the most accurate change score for discriminating between improved and stable patients.
- New patient to follow-up ratio (NP:FU) - depending on the service there is often a 'target' ratio which is generally less than six follow-up appointments to every initial appointment on average. Services such as musculoskeletal physiotherapy would be expected to meet a lower ratio of 1:5, whereas services treating long term, progressive conditions will demonstrate higher ratios. Low ratios are not at the expense of clinical outcomes but demonstrate effective and efficient treatment.
- Functional assessment of burns (FAB) review - burns standards state that FAB assessments must be carried out within 24 hours of admission.

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

		Target	2013	2014	2015
Effective (clinical outcomes)	PSFS change (MSK)	≥ 3	4	4.2	4.2
	Quick DASH change (Hands)	>7	N/A	29.5	27.4
Effective (NP:FU)	NP:FU ratio (Physio)	≤ 5	4.2	4.6	4.1
	NP:FU ratio (OT)	≤ 5	3.9	4.9	4.5
	NP:FU ratio (SALT)	≤ 5	4	4.6	3.2
	NP:FU ratio (Dietetics)	≤ 5	3	3.7	4.2
	Average NP:FU ratio	≤ 5	3.8	4.5	4
Patient experience	FFT % likely/very likely to recommend service	>90%	N/A	N/A	95%
	FFT % unlikely/very unlikely to recommend service	<1%	N/A	N/A	0.7%
	Patient satisfaction - MSK (%)	>90%	98%	98%	100%
	Burns standard - FAB review within 24hrs (weekdays) (%)	>90%	N/A	N/A	100%

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.

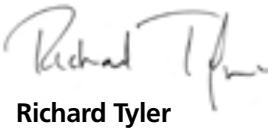
In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2015/16* and supporting guidance;
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2015 - May 2016
  - papers relating to quality reported to the board over the period April 2015 - May 2016
  - feedback from commissioners dated 13 May 2016
  - feedback from governors dated 19 May 2016
  - feedback from Healthwatch West Sussex dated 16 May 2016
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, anticipated July 2016
  - QVH Picker national inpatient survey results, January 2016
  - CQC national inpatient survey results, anticipated June 2016
  - QVH national staff survey results, 22 March 2016
  - the head of internal audit's annual opinion over the trust's control environment dated May 2016
  - official report from the Care Quality Commission dated 26 April 2016
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the quality report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm 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.improvement.nhs.uk).

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
23 May 2016



Richard Tyler
Chief Executive
23 May 2016

Statements from third parties

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

Crawley and Horsham and Mid Sussex CCGs welcome the opportunity to comment on the 2015/16 quality account for QVH.

The commissioners have worked closely with the trust during the year, gaining assurance of the delivery of safe and effective services. Presentation of a wide range of indicators in relation to quality, safety and performance is presented and discussed at regular meetings between the trust and the CCGs. We acknowledge that this quality account mirrors the information given to the commissioners throughout the year, and the strengthened governance improvements made during the year have been noted.

A review of regulatory inspection is part of the CCGs' quality assurance process and the 'outstanding' rating given for care for the specialist burns and plastic services was a huge achievement, and the overall rating of 'good' reflects the enormous amount of work undertaken by a relatively new leadership team and the staff. We acknowledge the increased emphasis on quality improvement initiatives and risk management and are pleased to note this has been reflected in the three priorities set for 2016/17 built upon patient feedback and other stakeholders.

We acknowledge the openness and honesty with the end of year progress against 2015/16 priorities that not all were met but welcome the pilot for skin patients to enable improvement in the patient experience for the scheduling of elective surgery and roll out across other specialities in 2016/17.

The CCGs note the challenges for the intensive care unit and out of hours cover. This is reflected and clearly evidenced within the document, and the Sign up to Safety pledges have been included in the local CQUINs set for 2016/17.

The commissioners are pleased to endorse this quality account for 2016/17 and we look forward to continuing our excellent relationship so we can all drive forward the improvements and ensure excellent services for the local population.

Statement from Healthwatch West Sussex

Healthwatch West Sussex has worked closer with the trust this year, jointly reviewing performance from the patient and public perspective. For example, we have been involved in the patient engagement group, through independent patient involvement in assessing the quality of the patient environment through the annual PLACE audits, and the quality accounts prioritisation and criteria selection process.

We commend the trust on the overall 'good' rating across the five domains and 'outstanding' rating from the CQC for patient care. We recognise that this achievement has involved a great deal of work for the team. It is good to see that this is being continued in the three priorities identified for 2016/2017: patient safety, clinical effectiveness and patient experience, to continue to build on the work in these areas of 2015/16.

It is good to hear of the shared decision and co-productive ways of working between staff and patients, including telephone clinical reviews. The improvements in catering for patients over the year are excellent. It is good to learn of the new ideas such as the red tray system being implemented.

It was really good to hear about the amount of work in the Duty of Candour area; reporting aligned to the incident reports, patient information leaflet and staff training. This is good progress and reassuring that it is ongoing. That the results for complaints have reduced year-on-year and most are resolved by the trust, is an indicator that robust and appropriate processes are being used and communicated.

The trust and staff are to be commended on the volume of initiatives reported, and standards achieved, regional and national. With regards to the report a glossary would be a useful addition. As cited by Monitor (March 2016, page 4) 'Quality reports help trusts to improve public accountability for the quality of care they provide'. Therefore it is vitally important that the information is clear and consistent, and that each item has a clear plan of action for the coming year.

Healthwatch West Sussex looks forward to continuing to work with the trust next year from the patient and public perspective.

Statements from third parties

Statement from QVH Council of Governors

Whilst governors welcome the ambitious intent to reduce investigation times, they also feel that it is good that QVH recognises that not all investigations (especially the complex cases) will be completed within the targeted timeframes.

The governors note the high standard of quality with regard to the sentinel node biopsy and breast surgery.

It is really good that dementia services and attitudes are praised. One would not expect a purely surgical hospital to do so well in this regard.

It is good that food and catering are improving but the governors recognise that there will always be discontent from some people, especially when they are unwell and are in a postoperative state.

Whilst the governors note the merits of the 'Hello, my name is…' initiative, they nevertheless feel that there is no justifiable reason for staff not introducing themselves personally to patients and visitors.

Governors are delighted to see that QVH is taking pressure ulcers seriously.

Governors note that while QVH is better than the national average for bullying and harassment, they remain concerned that 13% of staff feel bullied and harassed at least once or twice in the last 12 months. Governors expect to see improvement in this area.

Finally, the results, particularly from the CQC inspection, do give thoroughly deserved credit to the staff at QVH. The judgement of 'requires improvement' for critical care is, in part, understandable as it would be impossible to replicate district general hospital or teaching hospital standards on the QVH site. Governors note that the trust recognises this deficiency and makes every effort to improve patient safety and continuity of care.

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 2016 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following two national priority indicators (the Indicators):

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

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 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2015/16 ('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 supporting guidance 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 supporting guidance and consider the implications for our report if we become aware of any material omissions.

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

- board minutes and papers for the period April 2015 to May 2016;
- papers relating to quality reported to the board over the period April 2015 to May 2016;
- feedback from commissioners dated 13 May 2016;
- feedback from governors dated 19 May 2016;
- feedback from Healthwatch West Sussex dated 16 May 2016;
- the 2015 national patient survey dated January 2016;
- the 2015 national staff survey dated 22 March 2016;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, in the period April 2015 to May 2016;
- feedback from West Sussex County Council Health and Adult Social Care Select Committee dated April 2016;
- official report for the Care Quality Commission dated 26 April 2016; and
- the 2015/16 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 2016, 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 indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

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

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.

Basis for qualified conclusion

As set out in the statement on the Annual Quality Report from the Chief Executive of the Foundation Trust on pages 52 to 53 of the Trust's Annual Governance Statement, the Trust currently has concerns with accuracy of data with regards to the 18 week RTT and 62 day cancer waits indicators.

With regards to the 18 week RTT indicator, we identified control weaknesses in the design of the system and data weaknesses within the first quarter of 2015/16. We identified that there is a weakness in the design of the controls for 18-week RTT, as the data from the satellite site at Medway Hospital is not included as a matter of policy due to unavailability and incompatibility of data provided for activity at this site. Procedures specified for reporting purposes were followed by the clinical team, however, our testing identified that the indicator is not complete. In addition, detailed sample testing of this indicator identified four errors, where there were discrepancies between clock start and stop times recorded on the Patient Administration System ("PAS") and patient referral letters.

As a consequence, we are unable to give limited assurance on the 18 week RTT indicator included in the published Quality Report for the year ended 31 March 2016.

With regards to the 62 day cancer waits indicator, we identified control weaknesses in the design of the system and data weaknesses within the first quarter of 2015/16. In addition, our testing identified seven errors within the data comprising the indicator.

As a consequence, we are unable to give limited assurance on the 62 day cancer waits indicator included in the published Quality Report for the year ended 31 March 2016.

Independent auditor's report to the council of governors

Qualified conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance; 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

25 May 2016