Queen Victoria Hospital
NHS Foundation Trust

QUEEN VICTORIA HOSPITAL
NHS FOUNDATION TRUST
Annual Report and Accounts 2020/21

QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST

Annual Report and Accounts 2020/21

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

CONTENTS

1 Introduction

Chair's introduction

I suspect that the chair of every NHS organisation in the country will be starting their annual report with the reflection "well, that wasn't the year we were expecting"! They will also – quite rightly – be paying tribute to all their staff who have worked so hard and with great dedication throughout this extraordinary year.

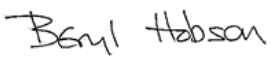
Queen Victoria Hospital (QVH) played a unique role during the enormous upheavals of 2020/21. While other trusts reorganised services to accommodate covid patients, we transformed into a regional cancer hub, ensuring that patients from across the south east with high risk breast, skin and head and neck cancers who would normally have been treated elsewhere could continue to receive vital surgery at QVH. Our staff continued to demonstrate the unstinting focus on the individual care of patients for which we are known.

In the spring of 2020, all our staff got behind the changes needed to redesign surgical pathways, implement covid screening and testing, and to move hundreds of administrative staff to home working to protect them and our patients. One of the highlights of the year was the QVH vaccination hub. For four weeks, staff volunteered for additional work and changed roles, bringing together the logistical knowledge and clinical expertise needed to set up a centre, book in and vaccinate some 2,000 health and care staff. QVH staff also worked in the public vaccination hub in Crawley. It was of course done with the usual QVH skill, good cheer, care and compassion, bringing a wave of well-deserved positive feedback.

Our board and council of governor meetings moved to virtual formats and, whilst we were prepared for exceptional business continuity measures, there was in fact no reduction in the level of assurance and understanding that we were able to obtain on the work of the hospital. As a board we recognised that there would be some positive changes to emerge from the pandemic – for example the increased use of video consultations which we know have saved some of our patients many hours of travel time. We also took the opportunity to consider what we had started doing which we would want to continue (or drop) and what we had stopped doing that we wanted to reinstate or stop permanently.

For some years we have been talking about the need to secure a long-term sustainable future for QVH. For obvious reasons our thinking on this has progressed more slowly than we would have expected pre-pandemic. We continue to engage with our staff and stakeholders as we consider whether joining the newly formed University Hospitals Sussex NHS Foundation Trust is the right thing for QVH. We are looking to the future with all the additional confidence that comes from the positive recognition QVH has rightly attracted for the vital role we have played in the wider NHS system over the last 12 months.

This will be my final report as chair of this amazing hospital. I would like to thank everyone that I have worked with over the last seven years, in particular the many board colleagues I have had the pleasure of working alongside throughout my two terms as chair. All the staff here, both clinical and non-clinical, work together as one to ensure that this is a well-run hospital that continues to provide outstanding care for our patients. I would like to extend my personal thanks to each and every one of them.



Beryl Hobson
Chair
10 June 2021

2 Performance

Overview of performance

Statement from the chief executive

The last year was an exceptional period for every part of the NHS. At the time of writing, QVH has stepped up to take on additional cancer surgery through two waves of covid, including welcoming visiting surgeons from other trusts to operate on their patients at QVH with the support of our expert teams. We also provided support to other trusts through our diagnostics and sleep services, and mutual aid in terms of PPE and staffing. We continue to use our redesigned surgical pathways to ensure QVH is able to deliver specialist care. Building on our early adopter status, we continue to screen front line staff using Optigene and more recently have added lateral flow home testing for all staff working on site.

We should not forget how, in the early days and weeks of covid and in the face of uncertainty and fear, when most people were staying at home, our staff were here for our patients day and night. Our clinical teams were supported by all the staff who moved to working from their kitchen tables and spare rooms. They were bolstered by the generosity of our hospital charity's supporters who enabled us to provide free hot meals for staff on site and donated everything from handmade washable laundry bags to shampoo for our hard working teams.

It is very 'QVH' that, although we are the second smallest trust in the country, we have as many staff as any other trust signed up to the national SIREN research project. The SARSCoV2 Immunity and Reinfection Evaluation study is looking at prevalence and the protection offered by antibodies. This important research will advance global knowledge about the virus and contribute to helping us manage and - hopefully, in time - eliminate covid.

The internet enabled us to rapidly scale up what was a virtual clinics pilot when covid hit. It is clear that telephone and video consultations are benefiting patients who previously used to travel for several hours for relatively brief appointments with our clinical experts. Alongside that, we need to make sure we have the right alternatives for those who are digitally excluded and those with a clinical need to be assessed face to face. As a surgical hospital, our patients will of course come to our theatres and we need to continue to work on how technology can support us in doing that efficiently and safely.

Throughout the past year, the QVH response to covid has been firmly rooted in the wider system response. Everything we have done - from vaccinating our staff and other local health and social care workers to physically moving services on our site to maximise infection control - has been part of a collaborative multidisciplinary and multi-organisational approach.

Covid has not gone away. At the time of writing, we are still staffing our incident room seven days a week and participating in regular system meetings to ensure the situation is well managed, based on the most up to date data. It is inevitable that covid has had a significant impact on planned care and much of our focus going forwards will be on what we need to do for the thousands of patients who have now joined our waiting lists.

Our finances worked very differently over the last year, with a national emphasis on ensuring all trusts were funded for the work they carried out. This meant that the growth of QVH's underlying deficit was temporarily paused.

QVH staff have done an incredible job over the last year, providing life changing services for patients from across the south east and beyond. The Trust's ability to do that in the

context of all the challenges of covid, should reinforce our ambitions to face future challenges secure that there is a positive future for the hospital, our services and our staff.

Chief Executive and Accounting Officer
10 June 2021

Statement of the purpose and activities of the Foundation Trust
QVH is a regional and national centre for maxillofacial, reconstructive plastic and corneoplastic surgery, as well as for the treatment of burns. It is a surgical centre for skin cancer, head and neck cancer, and provides microvascular reconstruction services for breast cancer patients following, or in association with, mastectomy.

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

In 2020/21, the principal activities of the Trust were the provision of:

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

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

- Brighton and Sussex University Hospitals NHS Trust (since 1 April 2021 part of University Hospitals Sussex NHS Foundation Trust)
- Dartford and Gravesham NHS Trust
- East Sussex Healthcare NHS Trust
- East Kent Hospitals University NHS Foundation Trust
- Kent Community Health NHS Foundation Trust
- Maidstone and Tunbridge Wells NHS Trust
- Medway NHS Foundation Trust
- Surrey and Sussex Healthcare NHS Trust.

QVH also receives referrals from these hospitals. In 2020/21, hundreds of patients from other hospitals in the south east were able to receive their cancer surgery at QVH with surgeons from other trusts operating at QVH alongside our expert theatre teams.

A brief history of the Foundation Trust and its statutory background
QVH is a specialist NHS hospital providing life-changing reconstructive surgery, burns care and rehabilitation services for people across the South of England.

Our world-leading clinical teams also treat common conditions of the hands, eyes, skin and teeth for the people of East Grinstead and the surrounding area. In

addition, we provide a minor injuries unit, expert therapies and a sleep disorders service.

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

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

Key issues, opportunities and risks that could affect the Foundation Trust in delivering its objectives and/or its future success and sustainability
The Trust has developed its strategic emphasis across five key strategic objectives. These are set out below and include details of the principal risks identified in each case.

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

During 2020/21 the principal risk to delivering outstanding patient experience has been the covid pandemic. The organisation has made significant changes in the estate and the clinical pathways to maintain patient safety throughout the pandemic. We invested in point of care testing for staff and patients to ensure rapid identification of covid infection. Alongside preoperative screening and support, this has enabled QVH to safely function as a cancer hub for the region throughout the pandemic.

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

As described above, changes to pathways and collaboration with the wider NHS system have enabled QVH to function as a cancer hub throughout the pandemic; the challenge resulting from this is the impact of this extra activity on more routine clinical work. We have embraced new technologies and adapted our working practices, including virtual service provision and one-stop pathways to reduce the need for multiple visits to the site. We have introduced, and continue to operate, additional clinical review processes for patients waiting for surgery to balance the risks of covid and non-covid harm.

There continue to be clinical services that have staffing challenges, especially in smaller teams, and this has been a greater risk over the last year with the frequent need for staff to undertake periods of isolation. This has been mitigated to some extent with new ways of working, in particular virtual clinics.

3. Operational excellence
We provide services that ensure patients are offered choice and are treated in a timely manner

The principal risks to delivery of this objective are the significant waiting list backlogs due to covid, availability and capacity of some specialist clinical staff across our sites and available theatre capacity.

The Trust is working collaboratively with other providers to support waiting times across the NHS locally. We are also considering whether being part of a larger trust could help us to develop a clear future strategy for our services benefiting patients across the

region. There may be ongoing opportunities for QVH to continue to support other hospitals with diagnostics.

4. Financial sustainability
We maximize existing resources to offer cost effective and efficient care whilst looking for opportunities to grow and develop our services.

The finance regime for 2020/21 was changed due to the covid pandemic and all trusts were funded at total cost for the first half of the year. For the second half of the year, the Trust was allocated a financial envelope through the Integrated Care System (ICS). The Trust was able to deliver its services within this envelope. This block contract arrangement will still be in place for the first half of the new financial year, however the contracting arrangements for the second half of the year are still unclear and further guidance will be provided.

Although the Trust was able to deliver its financial obligations in year, the future funding regime and its impact on the Trust's underlying deficit are unclear.

5. Organisational excellence
We seek to be the best place to work by maintaining a well led organisation delivering safe, effective and compassionate care through an engaged and motivated workforce.

Despite the pandemic we maintained, and in some areas slightly improved, performance against key indicators for this objective. Through the pandemic we protected staff with high levels of infection prevention and control and technological solutions to support segregated and home working. Our overseas recruitment campaign was suspended and resumed again in January 2021. Bank and agency use reduced significantly and did not return to pre-covid levels in year. Our staff education and learning offers were re-designed for virtual delivery and there was an increased take up of e-learning for mandatory and statutory training. Staff survey scores remained relatively stable with a slight increase in the overall response rate as described elsewhere in this report.

Going concern
These accounts have been prepared on a going concern basis.

The Trust is required under International Accounting Standard 570 to undertake an assessment of the NHS Foundation Trust's ability to continue as a going concern. Due to the materiality of the financial position, the board has carefully considered whether the accounts should be prepared on the basis of being a going concern.

The board considered that the definition of going concern in the public sector focuses on the expected continued provision of services by the public sector rather than organisational form. The financial statements of all NHS providers and clinical commissioning groups will be prepared on a going concern basis unless there are exceptional circumstances where the entity is being or is likely to be wound up without the provision of its services transferring to another entity in the public sector. In keeping with a number of other NHS trusts working in the current financial regime, the Trust is assured of access via NHS England and Improvement to financial resources to support the financial position.

There is no prospect that within the next 12 months, or the foreseeable future, health services will cease to be provided from the Queen Victoria Hospital site. At present the Trust is investigating a potential merger, if the merger progresses within 12 months from the date of signing the accounts this would not impact on the Trust's going concern status as its services would continue to be provided within the public sector.

Control total
The 2020/21 financial regime was broken into two elements. In the first six months, the Trust was funded at full cost and achieved a break-even position in line with all NHS provider organisations. For the second six months, the Trust was allocated a block contract envelope in line with spend in the first six months of the financial year. Due to the financial regime the Trust achieved a £3m surplus at year end.

Directors' statement regarding going concern
After making enquiries, the directors have concluded that there is sufficient evidence that services will continue to be provided. In reaching this conclusion, the board considered the financial provision within the forward plans of commissioners, efficiency plans and the recognised role of the Trust within the Sussex Health and Care Partnership and the wider regional health care system. The Trust's cash flow provision will be dependent on both acceptance and delivery of the financial recovery plans and support from the Department of Health and Social Care (DHSC). As with any Trust placing reliance on other DHSC group entities for financial support, the directors acknowledge that there can be no certainty that this support will continue although, at the date of approval of these financial statements, they have no reason to believe that it will not do so.

Based on these indications the directors believe that it remains appropriate to prepare the accounts on a going concern basis. The financial statements do not include any adjustments that would result from the basis of preparation being inappropriate.

2.2 Performance analysis

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

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

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

- To assure the board of directors of in-year delivery of financial and performance targets, the finance and performance committee maintains a detailed overview of the Trust's assets and resources. This includes the achievement of its financial plans; the Trust's workforce profile in relation to the achievement of key performance indicators (KPIs); and the Trust's operational performance in relation to the achievement of its activity plans.

- On behalf of the board of directors, the quality and governance committee is responsible for the oversight and scrutiny of the Trust's performance against the three domains of quality (safety, effectiveness and patient experience); compliance with essential professional standards; established good practice; and mandatory guidance and delivery of national, regional, local and specialist care quality targets.

The Trust's governance and assurance processes continued through the pandemic, making use of virtual meetings.

Analysis and explanation of development and performance

Care quality
The overall rating for the hospital remains as 'good' with a rating of 'outstanding' for care. The Care Quality Commission (CQC) did not undertake any face to face inspections during 2020/21 due to the covid pandemic. The CQC relationship manager meets virtually with the Trust on a regular basis. The Trust paused the compliance in practice visits to all clinical areas during the pandemic and these are scheduled to restart in summer 2021. Quality is continually monitored by the clinical governance group and the quality and governance sub-committee of the board, and a range of quality metrics are discussed at board level. The Trust is fully compliant with the registration requirements of the CQC.

Infection control
QVH had 7 hospital acquired cases of Clostridium difficile, no E. Coli bacteraemia, no hospital acquired cases of Covid-19 and no hospital acquired MRSA bacteraemia in 2020/21.

There were two Covid-19 outbreaks in non-clinical departments; an outbreak is two or more test-confirmed cases of Covid-19 among individuals associated with a specific non-residential setting with illness onset dates within 14 days. There was no impact from this on patient care or experience.

Waiting times
In 2020/21 waiting times have been severely impacted by the covid pandemic. This has been driven by the standing down of all non-urgent activity as directed nationally in wave 1, the mobilisation of QVH as a cancer hub in both waves 1 and 2 and the management of patients who are clinically vulnerable. The total waiting list size has increased since the end of year as referral rates have started to recover.

The total number of patients waiting longer than one year for treatment has increased substantially as capacity has been utilised for the management of cancer and other patients prioritised for their clinical need. However, performance has remained ahead of plan.

	Q1	Q2	Q3	Q4
Patients waiting longer than 52 weeks	185	555	623	903
Referral to treatment within 18 weeks (target 92%)	50.4%	55.6%	71.36%	70.22%
Total waiting list size	9854	10282	10069	11002

Figures shown are month end for each quarter

Cancer waiting times
Throughout 2020/21 QVH worked to improve cancer times for patients. An improvement plan is in place and the Trust has made good progress in delivering the new faster diagnosis standard.

The two-week wait standard (maximum time from urgent GP referral for suspected cancer to first hospital assessment) fell in quarter one due to the need for patients to self-

isolate in advance of treatment but has recovered well throughout the remainder of the year.

	Q1	Q2	Q3	Q4
Patients beginning first definitive treatment within 62 days following urgent GP referral for suspected cancer	88.2%	85.3%	85.7%	87.7%
31 day decision to treat	93.1%	89.7%	92.8%	94.6%
Two week wait referral for suspected cancer	77.1%	99.7%	98.9%	98.8%
Faster diagnosis standard (Shadow monitoring)	82.5%	82.2%	73.7%	83.2%

Figures shown are month end for each quarter

Equality of service delivery to different groups
All Trust policies are subject to an equality impact assessment to ensure no adverse impact on patients or staff with protected characteristics. In line with the public sector equality duty, the Trust also works to reduce or remove the disadvantage suffered by people because of a protected characteristic, for example ensuring alternative pathways for patients with learning difficulties or dementia who often cannot tolerate a nose and throat covid swab. We review patient feedback in both the national friends and family test and the annual national inpatient survey by gender, age, disability and ethnicity, checking for any emerging issues requiring action. In the context of growing waiting lists, work is underway to increase the comprehensiveness of information on patients' protected characteristics, including ethnicity coding, in order to monitor equality of access. The Trust is also working with the ICS to agree a wider approach to addressing health inequalities.

Financial plan
In 2020/21 the Trust was working under the revised national financial regime due to the pandemic, with all elective care suspended for the beginning of the year. This revised framework was operational for all NHS provider organisations.

The funding regime was based on a block contract arrangement to cover all of the Trust's costs in the first six months of the year. For the subsequent six months the Trust was given a financial allocation through the ICS, including an allocation of anticipated spend related to covid. Late notice of funding and a slower recovery of activity due to the second wave of the pandemic resulted in the Trust making a £3.0m surplus.

Key financial indicators
The Key Financial performance indicators for 2020/21 are detailed in the table below

	Plan £000	**Actual £000**
Reported financial performance	(£483)	£3,017

The accounts report a surplus of £3,017k which equates to an adjusted surplus on a control total basis of £2,478k, excluding impact of net impairments resulting from valuation of land and buildings £(232k); Department of Health and Social Care (DHSC) 'donated' personal protective equipment consumables stock balance £(341k); and the net impact of donated income less donated depreciation of £34k.

Statement of comprehensive income
Below is an extract of the table from the accounts (section 6) that shows the total value for income and expenditure for the financial year.

	2020/21
	£000
Operating income from patient care activities	70,786
Other operating income	14,365
Operating expenses	(80,740)
Operating surplus/(deficit) from continuing operations	**4,411**
Finance income	1
Finance expenses	(127)
PDC dividends payable	(1,268)
Net finance costs	**(1,394)**
Other gains / (losses)	-
Surplus / (deficit) for the year	**3,017**
Other comprehensive income	
Will not be reclassified to income and expenditure:	
Impairments	(171)
Revaluations	842
Total comprehensive income / (expense) for the period	**3,688**

Land and buildings were revalued as at 31 March 2021 by professionally qualified, Royal Institute of Chartered Surveyors (RICS) registered, valuers Gerald Eve LLP on a desktop basis. For 2020/21 the valuer, in arriving at the 31 March 2021 valuation, applied the following considerations:

- Operational Assets continue to be valued using a Modern Equivalent Asset Valuation (MEA) on an alternative site basis.
- The valuation took account of changes in building cost market values since the full valuation at 31 March 2020.
- The valuer also took note of maintenance and enhancements undertaken by the Trust since the full valuation at 31 March 2020.
- The Trust has entered into an agreement to sell a small parcel of land (approximately 1.5 hectares). As the site is valued on a MEA Alternate site basis, no value has been associated with the land within the 2020/21 accounts.

Income

Total income for the Trust was £85.2m an increase of £12.8m on last year due to the change in financial arrangements due to the pandemic. The Trust received £70.8m for the provision of patient care activities. The Trust received other operating income of £14.4m, this included £2m for centrally allocated personal protective equipment (PPE), £9.9m for top up support on top of the block payments for 2020/21 and £1.6m from Health Education England to support the cost of providing training and education to medical and other NHS staff.

Operating expenses

The Trust incurred £80.7m of operating expenses in 2020/21. This includes £55m (68% of total operating expenditure) to employ, on average over the year, 983 members of staff.

Operational non-pay expenditure includes supplies and services costs of £13.3m, drug costs £1.1m, premises costs £4.3m, depreciation and amortisation of £ 3.6m, clinical negligence premium £0.8m.

Capital
The Trust invested in a £4.4m capital programme within the financial year.
Expenditure by asset class as follows:

Asset class	**£000**
Building enhancements	729
Assets under construction	616
IT	1,110
Plant and Machinery	1,679
Intangibles	242
	£4,376

Included in the above, £79k relates to cash donations from the QVH Charity and League of Friends Charity to support medical equipment purchases, and DHSC donated diagnostic equipment valued at £175k as part of the pandemic response

Cash
The Trust has a cash balance of £8.6m, which represents c.39 days of operating expenditure. The majority of funds are held with the Government Banking Service (GBS)

Revenue Loans converted to Public Dividend Capital (PDC)
In 2020/21 the Department of Health and Social care issued Public Dividend Capital to the Trust of £6,391k to convert the historic revenue loans drawn by the Trust. No interest was payable on the revenue loans from 01 April 2020. The Trust still holds an interest bearing capital loan that was drawn in 2011 to fund the development of the Trust theatres: 31 March 2021 liability value £4,302k.

Environmental and sustainability report

The key sustainability objectives are:

- To continue to reduce our carbon footprint year on year through behavioural change and by introducing low carbon technologies in our ongoing commitment to reduce carbon
- To embed sustainability considerations into our core business strategy
- To procure goods and services in a sustainable manner
- To work with other NHS organisations in the Sussex Health and Care Partnership on our shared carbon reduction process - programmes such as a shared courier service and pathology transportation services are currently being reviewed
- To reduce both general and clinical waste in line with NHS England directions.
- To consider the design and operation of our buildings which includes the recent installation of a more modern building management system (BMS) to control our plant more economically
- To implement phased action plans to address energy, water and carbon management reduction programmes, including the use of programmable time clocks to assure that all key plant and equipment is operated to an environmentally acceptable standard.

In 2020/21 key successes included:

- A review and reduction of overnight electricity consumption in theatres
- Continued installation of variable speed drives to larger fan motors, connected to the building management system so efficiency gains can be calculated

- A review of the BMS, seeking opportunities for carbon reduction
- Continuing the programme to replace existing lighting with low energy and low maintenance LEDs - phase 2 has been completed and now all key areas are lit with energy efficient lighting
- Full participation in Sussex integrated care system carbon efficiency scheme review.

Specific carbon-reducing projects identified for implementation in 2021/22 are:

- Further review of the newly installed BMS to assure that all plant is operating efficiently and offering energy savings.
- Ongoing development alongside other partners in the ICS in the further development of Our Green Plan; previously known as the Sustainable Management Development Plan
- Review of catering food waste identifying ways to use the food waste efficiently either by way of a bio-enzyme digesting the waste or an alterative
- Review of heating systems and boilers to ascertain alterations that can be made to progressively adapt or replace carbon-producing boilers and heating systems to make them more ecologically friendly
- The installation across the hospital of more cycle ranks and safe storage boxes for those staff and visitors who wish to cycle to the hospital
- Installation of further electric vehicle charging points to allow the greater use of electric car usage by staff and patients.

Waste		2016/17	2017/18	2018/19	2019/20	2020/21
Recycling	(tonnes)	0	68	187.3	33.76	28.475
	tCO_2e	0	1.43	3.93	1.76	1.65
Other recovery	(tonnes)	106	155	42.78	81.2	62.58
	tCO_2e	2.12	3.26	0.89	1.78	1.335
High temp disposal	(tonnes)	0	0	0	0	0
	tCO_2e	0	0	0	0	0
Landfill	(tonnes)	44	85	0	0	0
	tCO_2e	10.75	26.35	0	0	0
Total waste (tonnes)		150	308	230.08	114.96	91.05
% Recycled or reused		0%	22%	81%	100%	100%
Total waste tCO_2e		12.87	31.03	4.83	3.54	3.18

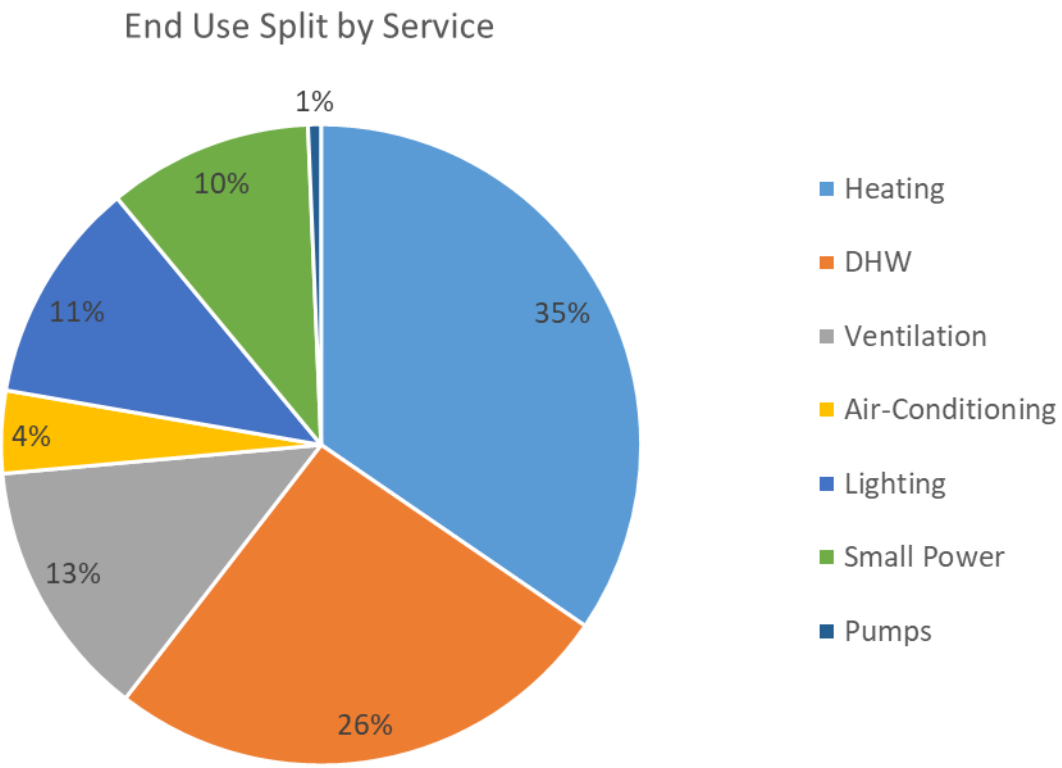
Hospital Breakdown

		Gas	Electricity					
	GIA	kWh/Year						
Building/Area	**GIA**	**Heating**	**DHW**	**Ventilation**	**Air-Conditioning**	**Lighting**	**Small Power**	**Pumps**
Jubilee Centre and Minor Injuries Unit	2146.5	261,706	174,950	0	2,279	149,416	98,766	3,292
Rehabilitation, Estates and Hotel Services	1176	342,786	88,154	0	0	17,795	53,386	2,818
Macmillan Information & Support Centre and Prosthetic clinic	863.1	192,445	157,455	0	5,175	12,651	39,102	0
Physio / Occupational Therapy	423	82,076	67,153	0	0	3,699	19,189	0
Main Out Patients Modulars	792	83,660	112,681	0	37,839	2,818	35,424	3,059
Canadian Wing and Pharmacy	2697	261,706	131,212	0	12,814	256,278	120,130	4,805
Day Surgery (New Skin Clinic)	397.3	71,113	53,481	0	0	5,804	17,896	97
American Wing and Rowntree Theatres	4077.6	729,850	548,891	0	160,350	314,018	180,393	2,672
Burn Unit (New HNU Ward)	1715	306,968	230,858	274,272	6,295	85,429	76,436	1,349
Peanut (New Burns Ward)	649	113,554	77,894	0	4,014	28,671	29,308	1,211
Paediatric Assessment Unit (New EBAC)	167	29,219	20,044	0	0	2,429	7,591	0
Medical Photography	193.3	33,821	23,200	0	0	2,810	8,782	0
Admissions / Speech Therapy	158.7	0	114,341	0	0	2,309	7,215	0
Blonde McIndoe Building	724	126,676	86,896	181,417	14,911	9,941	34,792	0
Theatres	4415.3	401,143	536,327	867,462	173,492	159,035	202,408	43,373
Corneo Plastic Clinic	498	87,134	87,134	0	3,256	42,948	22,167	208
Kitchens	1024.2	230,325	56,358	0	0	14,744	46,559	2,483
Surgeon's Mess and Health Records Stores	363.7	81,790	27,263	0	0	18,350	16,191	864
Gardens Store	100.8	23,639	0	0	0	1,465	4,579	0
Staff Development Centre	502	21,333	26,074	0	0	7,302	22,818	0
Hurricane Café	60.3	11,440	0	0	0	875	2,734	0

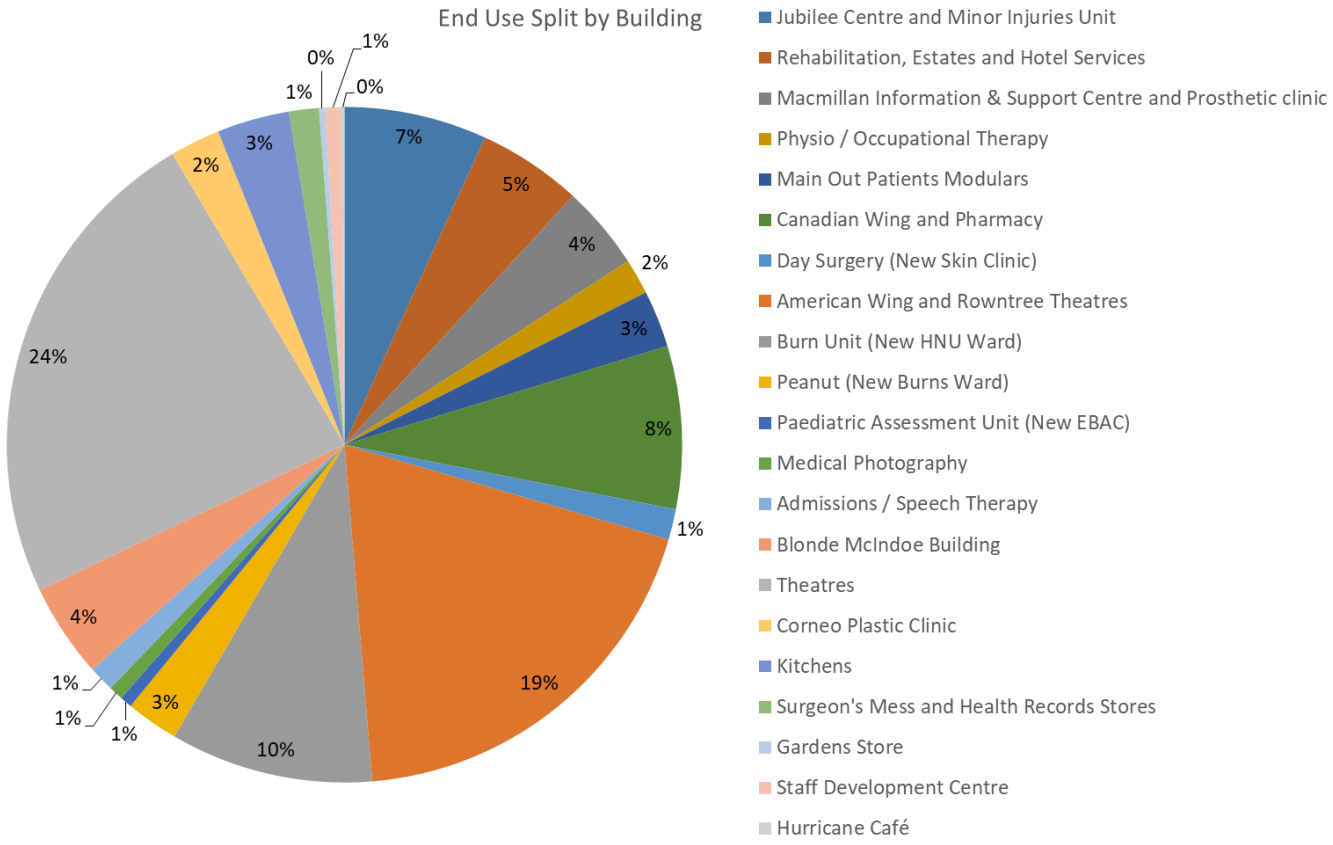
High to Low Consumption

Building/Area	Total	%
Theatres	2,383,239	23.61%
American Wing and Rowntree Theatres	1,936,175	19.18%
Burn Unit (New HNU Ward)	981,606	9.72%
Canadian Wing and Pharmacy	786,945	7.79%
Jubilee Centre and Minor Injuries Unit	690,410	6.84%
Rehabilition, Estates and Hotel Services	504,939	5.00%
Blonde McIndoe Building	454,633	4.50%
Macmillan Information & Support Centre and Prosthetic Clinc	406,828	4.03%
Kitchens	350,469	3.48%
Main Out Patients Modulars	275,480	2.72%
Peanut (New Burns Ward)	254,651	2.52%
Corneo Plastic Clinic	242,846	2.40%
Physio / Occupational Therapy	172,117	1.70%
Day Surgery (New Skin Clinic)	148,390	1.47%
Surgeon's Mess and Health Records Stores	144,457	1.32%
Admissions / Speech Therapy	123,865	1.22%
Staff Development Centre	77,527	0.76%
Medical Photography	68,613	0.67%
Paeddiatric Assessment Unit (New EBAC)	59,283	0.57%
Gardens Store	29,683	0.29%
Hurricane Café	15,049	0.14%

Pie Chart Usage split by service



Usage split by Building



Carbon Footprint

GHG emission data for period:	01 April 2020 - 31 March 2021
Emissions Source	**Tonnes of CO_2e**
	Current reporting year
Combustion of fuel and operation of facilities	1,157
Electricity, heat, steam and cooling purchased for own use	989
Total	2,146

Social and community issues
The Trust has engaged with stakeholders, including staff and governors, about its strategic plans for a number of years, including issues related to the scale of QVH as the second smallest trust in the country and an intention to address these challenges by building on existing partnership working. In the summer of 2020, key QVH partners Western Sussex Hospitals NHS Foundation Trust and Brighton and Sussex University Hospitals NHS Trust announced their intention to merge into a single organisation. In October 2020, a leaflet describing the Trust's approach to securing its long-term future in this context was circulated to a wide range of external stakeholders and made available on the Trust's website. In November and December 2020, QVH wrote on the subject to all south east MPs; NHS provider and commissioner partners; NHS England and Improvement; and a number of education and charitable stakeholders.

The board has been clear that a possible merger would be about securing the long term future of the hospital and its services. However, a public campaign has been launched which expresses concern about the ongoing availability of QVH's services. Elections to the QVH council of governors in winter 2020 took place in this context. While much of the content of the campaign is based on positive patient experiences at QVH, there has also been some inaccurate reporting suggesting an intention to restrict QVH services to Sussex patients only. We have been working through stakeholder communications and our public website, as well as an ongoing programme of staff engagement, to keep people informed about next steps.

Should the decision be taken to proceed to a full business case for the merger of QVH with the newly formed University Hospitals Sussex NHS Foundation Trust, the development of the full business case will be supported by a comprehensive communications and engagement plan, helping to ensure staff, patients, members and other stakeholders are informed and involved in the future organisational arrangements.

Anti-bribery and human rights issues
The rules and procedures relating to bribery are set out in the counter fraud policy, and those relating to the provision or receipt of gifts or hospitality are set out in the Trust's standards of business conduct policy. The Trust maintains a register of gifts, hospitality and sponsorship received and staff are made aware of the need to declare any potential conflict of interest**.**

Focussing on quality and patient experience we work alongside partner agencies to promote the safety, health and well-being of people who use our services. The QVH Safeguarding strategy includes a Human Rights Framework covering protection of vulnerable patients at QVH.

The procurement team has reviewed and updated policies and procedures which relate to the Trust's corporate responsibility for slavery and human trafficking. Mandatory questions regarding the Modern Slavery Act 2015 as well as the Bribery Act 2010 are included in new supplier forms and in tender packs.

Where there is concern regarding possible slavery or human trafficking of a patient, to determine appropriate action the patient is seen alone and an independent translator is used, in line with the Trust's safeguarding procedures. If this did not resolve any concerns, then a referral would be made to the police. No cases of slavery or human trafficking were identified in 2020/21.

Overseas operations
QVH has no overseas operations

3 Accountability

3.1 Directors report

Directors' disclosures
In 2020/21 the following individuals served as directors of Queen Victoria Hospital NHS Foundation Trust.

NAME	POSITION
Beryl Hobson	Chair *(voting)*
Paul Dillon-Robinson	Non-executive director *(voting)*
Kevin Gould	Non-executive director *(voting)*
Karen Norman	Non-executive director *(voting)*
Gary Needle	Non-executive director and senior independent director *(voting)*
Steve Jenkin	Chief executive *(voting)*
Michelle Miles	Director of finance and performance *(voting)*
Keith Altman	Medical director *(voting)*
Jo Thomas	Director of nursing and quality to 11/11/2020 *(voting)*
Nicky Reeves	Director of nursing and quality (interim) from 16/11/2020 *(voting)*
Abigail Jago	Director of operations *(non-voting)*
Geraldine Opreshko	Director of workforce and organisational development *(non-voting)*
Clare Pirie	Director of communications and corporate affairs *(non-voting)*

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

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

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

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

Other disclosures
In 2020/21 the Trust neither made nor received any political donations.
The better payment practice code requires QVH to pay all valid invoices within the contracted payment terms or within 30 days of receipt of goods or a valid invoice, whichever is later. The performance achieved in 2020/21 compared to 2019/20 is shown in section 6 of the annual accounts.

Better Payment Practice Code	2020/21 Number	2020/21 £000	2019/20 Number	2019/20 £000
Total non-NHS trade invoices paid	15,214	36,764	20,007	41,045
Total non-NHS trade invoices paid within target	13,673	33,720	17,817	36,510
Percentage of non-NHS trade invoices paid within target	89.9%	91.7%	89%	89%
Total NHS trade invoices paid	1,274	6,870	1,033	5,074

Fees and charges
During 2020/21, the Trust incurred consultancy costs of £31,500. This was for support to work on the strategic case for possible merger. The Sussex Health and Care Partnership funded the Trust for these costs in recognition of the need to secure a long term sustainable solution for the hospital.

NHS Improvement's well-led framework
QVH has had regard to NHS Improvement's well-led framework in considering the organisation's performance, internal control, board assurance framework and the governance of quality. More detail can be found in the annual governance statement below.

Patient care
As in previous years a detailed account of how the Trust delivers and monitors the quality of patient care is included in the quality report which will be available on the Trust's public website. This includes performance against key healthcare targets, arrangements for monitoring national improvements in the quality of healthcare, and patient experience.

Stakeholder relations
As described earlier in this report, QVH operates a networked model from its 'hub' hospital site in East Grinstead, West Sussex. Reconstructive surgery services (a mix of planned surgery and trauma referrals) are provided by QVH in 'spoke' facilities at other major hospital sites across Kent, Surrey and Sussex, and QVH also receives referrals from these hospitals. In addition, QVH provides community-based clinical services into which GPs can refer, based on a range of sites across Kent and Sussex.

We work closely with Brighton and Sussex University Hospitals NHS Trust (now part of University Hospitals Sussex) to support the delivery of our specialised services. We have a number of joint medical posts and QVH provides plastic surgery support to the major trauma centre in Brighton. QVH is working with University Hospitals Sussex to look at whether formalising our partnership working through merger would benefit our patients, our staff and the wider NHS. At the time of writing no decisions have been made.

Using feedback to improve services
We actively seek insights from patients, healthcare professionals, the public, and key stakeholders on the quality and effectiveness of our services to help inform service change and decisions. Our public and patient involvement activities encompass a broad range of approaches to enabling people to voice their views, needs and wishes, and to

contribute to plans, proposals and decisions about services. This includes a number of mechanisms for formally monitoring and reporting what patients say about their experience of QVH:

- National patient surveys – we participate in all relevant national surveys. While we receive consistently high response rates and predominantly positive feedback, we are not complacent and use this insight to inform further improvements.
- Patient advice and liaison service (PALS) contacts and complaints - we receive around 25 PALS contacts and five complaints per month and these are reviewed with a high level of detail at the quality and governance sub-committee of the board, and reported in summary to the board.
- Patient story at public board meetings - this is often a patient attending in person (more recently virtually) to describe their experience of care. This plays an important role in setting the tone of board meetings, ensuring we have patients at the centre of our thinking. It also provides real insight into our services from a patient's perspective.
- Ratings websites - we monitor and respond to online sites inviting patient feedback including Care Opinion and the NHS website. This forms an additional part of our reporting to the quality and governance committee and the board.
- QVH social media - we receive a considerable volume of patient feedback through the QVH Facebook and Twitter accounts. As well as using these to pass on thanks to staff, patients do sometimes use them to raise concerns which are passed to the patient experience manager immediately.
- Themes raised through all these routes are triangulated with national and local surveys and staff feedback to ensure we act on issues raised by patients.

The QVH patient experience group includes patient representatives, a learning disability representative, public governors and Healthwatch. The group has been involved in work such as improving our food and a programme reviewing the outpatient experience.

When QVH became a regional cancer hub during the first wave of the pandemic, this included ensuring safe and timely treatment for patients requiring surgery for breast cancer. This is not surgery usually performed at QVH, therefore the Trust sought additional feedback from this cohort of patients about their experience through a questionnaire undertaken between April and October 2020. We sent out 494 questionnaires and received 264 responses. We asked patients to tell us what we were doing right and where we could improve. Out of the responses, 262 patients found our service very good or good, one patient found our service neither good or poor and one patient found the service poor.

Although the vast majority of patients were pleased with the service, an early theme was the length of time that patients had to wait from arrival to the actual time of surgery. The findings were immediately fed back to the theatre team who were able to review the service and implement changes to reduce patient waiting time and improve communication with patients about unavoidable waits. A designated nurse kept patients updated about their position on the theatre list, helping patients to feel informed and reassured.

In June 2020, following national suspension, QVH reintroduced the friends and family test using the new national format:

We welcome patient feedback to tell us what we are doing right and what we can improve.

Thinking about our service, overall, how was your experience of our service?: very good / good / neither good nor poor / very poor / don't know

Please can you tell us why you gave your answer and if there is anything we could have done better?

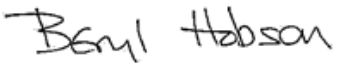
Although the numbers collected have been lower than usual, this is providing positive and helpful feedback.

Steve Jenkin
Chief Executive and Accounting Officer
10 June 2021

3.2 Remuneration report

Annual statement on remuneration
In 2020/21 the very senior management (VSM) pay guidance from NHS Improvement was delayed until December 2020. The correspondence made clear that this guidance was for both foundation and non-foundation trusts and no action could be taken on VSM pay until it was released. The QVH nomination and remuneration committee therefore postponed scheduled meetings earlier in the year.

Following receipt of the guidance, a meeting of the committee took place and the salaries of the executive directors and chief executive were increased, pro-rata, in line with NHS Improvement guidance. The committee remained assured that the Trust was in step with comparable benchmarked trusts at the median level.



Beryl Hobson
Chair of the nomination and remuneration committee
10 June 2021

Very senior managers' remuneration policy
The salary and pension entitlements of very senior managers are set out in the section below showing information subject to audit. The QVH approach to remuneration continues to be influenced by national policy, benchmarks and local market factors. The majority of staff receive pay awards determined by the Department of Health in accordance with their national terms and conditions, such as Agenda for Change, and the pay review bodies for doctors and dentists. All junior doctors at QVH are now on the new contract.

QVH does not intend to implement separate arrangements for performance related pay or bonuses unless further guidance from NHS England and NHS Improvement is issued.

All very senior managers' pay arrangements are subject to approval by the nomination and remuneration sub-committee of the board of directors.

In terms of new appointments, the committee is cognisant of the Trust's data in relation to gender pay gap, workforce race equality standard (WRES) and workforce disability equality standard (WDES), which are summarised in the Trust's annual equalities and diversity report. When vacancies have arisen the Trust has proactively encouraged applications from all communities.

In relation to agreeing and reviewing VSM pay, the committee refers to the existing guidance on pay for very senior managers in NHS trusts and foundation trusts published by NHS Improvement. The annual pay award for executive directors is recommended by NHS England and Improvement.

The committee takes account of the desire to have a board that is representative of the community and workforce it serves. Particularly in the case of new appointment considerations, the Trust will take account of its equality and diversity policies and action plan including those related to WRES and WDES as well as the impact on the gender pay gap. Further information is contained in the staff report.

The members of QVH nomination and remuneration committee agreed simple principles in relation to setting, agreeing and reviewing VSM pay. For new director appointments,

the director of workforce will review benchmarking data as well as seeking market intelligence on the salaries being offered to directors which will also take account of supply and demand at that time. The review of existing VSM pay will continue to take place once a year, the timing is dependent on information being published by NHSI/E and the committee will also take account of:

- The outcome of annual appraisals conducted by the chief executive (or chair in the case of the chief executive's pay)
- The level of the national pay award for the workforce on Agenda for Change
- Any extenuating circumstances or market conditions highlighted by the chief executive
- Updated benchmarking information and guidance.

The effectiveness and performance of very senior managers is determined through performance appraisal, linked to the Trust's five key strategic objectives from which a set of individual objectives are developed. These are reviewed through the year by the chief executive (or chair in the case of the chief executive) to determine progress and achievement. The Trust's key strategic objectives also underpin the board assurance framework which is reviewed at every board meeting and every committee to the board.

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

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

During 2020/21 the executive management team continued to oversee robust pay and vacancy controls for all roles through weekly virtual meetings.

Remuneration tables

The salary and pension entitlements of ~~very~~ senior managers and of non-executive directors are set out in the tables below showing information subject to audit. In line with national guidance, senior managers means those who influence the decisions of the NHS foundation trust as a whole rather than the decisions of individual directorates or sections within the NHS foundation trust. During the year one senior manager, the medical director, was paid more than £150,000. This level of remuneration reflects national pay scales for senior consultants and national clinical awards.

Service contracts obligations

There are no service contract obligations to disclose.

Policy on payment for loss of office

Termination payments are made within the contractual rights of the employee and are therefore subject to income tax and national insurance contributions. This applies to very senior managers whose remuneration is set by the nomination and remuneration committee. Where a very senior manager receives payment for loss of office, this is determined by their notice period. For all executive directors the notice period is three months and the chief executive six months.

Statement of consideration of employment conditions elsewhere in the Foundation Trust

The Trust, through the nomination and remuneration committee, takes into account the annual pay awards for all staff in determining pay increases for very senior managers and directors. Pay at senior levels were reviewed in 2020/21 in line with clear guidance

from NHSI/E and the nomination and remuneration committee approved the recommended fixed percentage sum increase (pro rata) to members of the executive team and chief executive. This took into account NHS Improvement benchmarking of very senior management pay across the UK.

Annual report on remuneration

Information not subject to audit

Service contracts

Name	Position	Start date	Term	Notice period
Steve Jenkin	Chief executive	14 November 2016	Permanent	6 months
Geraldine Opreshko	Director of workforce and organisational development	26 July 2017	Permanent	3 months
Abigail Jago	Director of operations	8 May 2018	Permanent	3 months
Keith Altman	Medical director	1 October 2019	Permanent	3 months
Clare Pirie	Director of communications and corporate affairs	1 May 2017	Permanent	3 months
Michelle Miles	Director of finance and performance	1 February 2018	Permanent	3 months
Nicola Reeves	Interim director of nursing and quality	16 November 2020	11 months	3 months

Nomination and remuneration committee

The nomination and remuneration committee meets to review and make recommendations to the board of directors on the composition, balance, skill mix, remuneration and succession planning of the board. Additionally, the committee makes recommendations on the appointment of executive directors. The board of directors has delegated authority to the committee to be responsible for the remuneration packages and contractual terms of the chief executive, executive directors and other very senior managers reporting to the chief executive.

The committee met four times in 2020/21. All meetings took place on a virtual basis due to the ongoing pandemic.

The director of nursing and quality took retirement at the end of November 2020. With an escalating pandemic and ongoing discussions related to the future form of the Trust, the chief executive recommended to the committee that an interim arrangement be considered as there was a natural successor in the deputy director of nursing and an opportunity to develop talent across a number of other clinical personnel.

The director of nursing and quality also fulfilled the role of deputy chief executive. The committee was recommended to consider proposals to recognise additional responsibilities of two directors, one to deputise for the chief executive and another to increase working hours to full time due to an unsustainable and increasing workload including a lead role in development and oversight of the strategic business case for change. Opinion and advice was sought from the specialist team at NHS England and Improvement to provide additional assurance to the committee in relation to the proposal.

The committee had a further meeting to agree the recommendations of NHS England and Improvement in relation to the annual VSM pay award.

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

The committee was materially assisted in its considerations at all meetings held in 2020/21 by Geraldine Opreshko, director of workforce and organisational development. This was in virtual attendance or by advice and guidance to the chair.

Disclosures required by the Health and Social Care Act
Information on the remuneration of the directors and on the expenses of directors is provided in the section which follows, setting out information subject to audit.

Governors
Information on the expenses of the governors is provided in the tables below.

01 April 2019 – 31 March 2020		
Total number of governors in office	Number of governors receiving expenses in 2019/20	Aggregate sum of expenses paid in 2019/20 (rounded to the nearest £00)
27 served for all of part of 2019/20	2	£600

01 April 2020 – 31 March 2021		
Total number of governors in office	Number of governors receiving expenses in 2020/21	Aggregate sum of expenses paid in 2020/21 (rounded to the nearest £00)
35 served for all of part of 2020/21	0	£0

Information subject to audit
Salary and pension entitlements of very senior managers

Senior Manager Remuneration Table 2020/21

SALARY AND PENSION ENTITLEMENTS OF VERY SENIOR MANAGERS																										
A) Remuneration table 2020/21																										
			2020/21			**2020/21**			**2020/21**			**2020/21**			**2020/21**			**2020/21**			**2020/21**			**2020/21**		
			Salary and fees (in bands of £5,000)			**Taxable benefits (total to the nearest £100)**			**Annual performance-related bonuses (in bands of £5,000)**			**Long-term performance-related bonuses (in bands of £5,000)**			**All pension-related benefits (in bands of £2,500) ****			**Other remuneration**			**Total**					
Senior Manager	**Role**	**Date References / Units**	**£000s, bands of £5k**			**£s, to the nearest £100**			**£000s, bands of £5k**			**£000s, bands of £5k**			**£000s, bands of £2.5k**			**£000s, bands of £5k**			**£000s, bands of £5k**					
Altman K *	Medical Director		170	-	175	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	**170**	-	**175**			
Dillon-Robinson P	Non-Executive Director		10	-	15	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	**10**	-	**15**			
Gould K	Non-Executive Director		10	-	15	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	**10**	-	**15**			
Hobson B	Chair		40	-	45	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	**40**	-	**45**			
Jago A	Director of Operations		105	-	110	-	-	-	-	-	-	-	-	-	52.5	-	55.0	-	-	-	**160**	-	**165**			
Jenkin S	Chief Executive		145	-	150	-	-	-	-	-	-	-	-	-	35.0	-	37.5	-	-	-	**180**	-	**185**			
Miles M	Director of Finance and Performance		125	-	130	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	**125**	-	**130**			
Needle G	Non-Executive Director		10	-	15	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	**10**	-	**15**			
Norman K	Non-Executive Director		10	-	15	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	**10**	-	**15**			
Opreshko G	Director of Workforce and Organisational Development		100	-	105	-	-	-	-	-	-	-	-	-	25.0	-	27.5	-	-	-	**130**	-	**135**			
Pirie C	Director of Communications and Corporate Affairs		85	-	90	-	-	-	-	-	-	-	-	-	50.0	-	52.5	-	-	-	**140**	-	**145**			
Thomas J	Director of Nursing and Quality	Retired November 2020	80	-	85	-	-	-	-	-	-	-	-	-	5.0	-	7.5	-	-	-	**85**	-	**90**			
Reeves N	Interim Director of Nursing and Quality	From November 2020	35	-	40	-	-	-	-	-	-	-	-	-	37.5	-	40.0	-	-	-	**70**	-	**75**			

*Salary attributable to the Medical Director's clinical role is £158k

** The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

Senior Manager Remuneration Table 2019/20

SALARY AND PENSION ENTITLEMENTS OF VERY SENIOR MANAGERS

A) Remuneration 2019/20

			2019/20	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20
			Salary & fees (in bands of £5k)	Benefits in kind	Annual performance-related bonuses (in bands of £5k)	Long-term performance-related bonuses (in bands of £5k)	All pension-related benefits	Other remuneration	Total
			£000s (Band of £5k)	£s (nearest £100)	£000s (Band of £5k)	£000s (Band of £5k)	£000s (Band of £2.5k)	£000s (Band of £5k)	£000s (Band of £5k)
Altman K *	Medical Director	from 1 Oct 2019	110 - 115	-	-	-	- -	-	110 - 115
Colwell V	Non-Executive Director	to 19 April 2019	0 - 5	-	-	-	- -	-	0 - 5
Dillon-Robinson P	Non-Executive Director	from 1 Oct 2019	5 - 10	-	-	-	- -	-	5 - 10
Gould K	Non-Executive Director		10 - 15	-	-	-	- -	-	10 - 15
Hobson B	Chair		40 - 45	-	-	-	- -	-	40 - 45
Jago A	Director of Operations		100 - 105	-			15.0 - 17.5		120 125
Jenkin S	Chief Executive		145 - 150	-	-	-	32.5 - 35.0	-	175 - 180
Miles M	Director of Finance and Performance		120 - 125	-	-	-	- -	-	120 - 125
Needle G	Non-Executive Director		10 - 15	-	-	-	- -	-	10 - 15
Norman K	Non-Executive Director	from 8 April 2019	10 - 15	-	-	-	- -	-	10 - 15
Opreshko G	Director of Workforce and Organisational Development		100 - 105	-	-	-	25.0 - 27.5	-	130 - 135
Owens L	Interim Director of Finance	3.2.20-26.03.20	25 - 30	-	-	-	- -	-	25 - 30
Pickles E	Medical Director	to 30 Sept 2019	70 - 75	-	-	-	- -	-	70 - 75
Pirie C	Director of Communications & Corporate Affairs		70 - 75	-	-	-	17.5 - 20.0	-	90 - 95
Thomas J	Director of Nursing		115 - 120	-	-	-	50.0 - 52.5	-	165 - 170
Thornton J	Non-Executive Director	to 30 Sept 2019	5 - 10	-	-	-	- -	-	5 - 10

*Salary attributable to the current Medical Director's clinical role is £107k

SALARY AND PENSION ENTITLEMENTS OF VERY SENIOR MANAGERS

B) Pension benefits table 2020/21

			Real increase in pension at pension age (bands of £2,500) £'000	Real increase in pension lump sum at pension age (bands of £2,500) £'000	Total accrued pension at pension age at 31 March 2021 (bands of £5,000) £'000	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000) £'000	Cash equivalent transfer value at 01-April-20 £'000	Real increase in cash equivalent transfer value £'000	Cash equivalent transfer value at 31-Mar-21 £'000
Jago	**A**	**Director of Operations**	2.5-5.0	2.5-5.0	25-30	50-55	383	52	442
Jenkin	**S**	**Chief Executive**	2.5-5.0	0	10-15	0	156	54	213
Opreshko	**G**	**Director of Workforce and Organisational Development**	0-2.5	0	5-10	0	94	32	128
Pirie	**C**	**Director of Communications and Corporate Affairs**	2.5-5.0	2.5-5.0	20-25	45-50	347	54	406
Thomas	**J**	**Director of Nursing and Quality ****	0-2.5	0-2.5	40-45	120-125	880	0	0
Reeves	**N**	**Interim Director of Nursing and Quality**	0-2.5	5-10	40-45	120-125	764	47	900

** Retired during 2020/21

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

No performance related bonus was paid in 2019/20 or 2020/21.

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

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

Fair pay multiple
Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in QVH in the financial year 2020/21 was £170k to £175k (2019/20, £185k to £190k). This was 5.3 times (2019/20, 5.9 times) the median remuneration of the workforce, which was £32k (2019/20, £32k). The reduction in this ratio is due to the highest paid director undertaking less additional clinical work than in the previous year, while the median workforce remuneration has remained the same.

In 2020/21, 4 (2019/20, 4) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £179k to £201k (2019/20 £198k to £213k).

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

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

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

Steve Jenkin
Chief Executive and Accounting Officer
10 June 2021

3.3 Staff report

Analysis of average staff numbers

2020/21 data													
PERMANENTLY EMPLOYED													
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Average**
Headcount	1069	1066	1070	1070	1067	1069	1072	1075	1077	1074	1078	1083	**1072**
FTE	907.73	904.90	909.68	910.49	909.61	913.14	916.43	920.52	922.28	919.86	924.50	927.65	**915.57**
TEMPORARY STAFF-BANK, LOCUM, AGENCY													
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Average**
Non-medical bank	35.66	28.20	30.87	42.22	53.88	51.76	56.84	60.75	59.90	69.31	62.74	83.75	**52.99**
Non-medical agency	7.42	4.24	4.87	5.70	5.86	9.83	8.93	10.19	9.89	10.40	9.14	9.53	**8.00**
Medical locums	1.77	3.42	2.25	4.29	3.72	3.62	6.32	3.74	4.29	5.83	2.96	3.06	**3.77**
Medical bank	1.86	1.45	1.65	1.03	1.53	2.23	1.56	2.1	1.25	1.07	0.71	1.01	**1.45**
Medical agency	1.06	0.92	1.10	0.00	0.95	1.33	1.28	1.76	1.70	0.92	0.92	1.09	**1.09**
Total average full time equivalent staff numbers 2020/21													**982.87**

The table above shows the average number of staff employed by the Trust each month in 2020/21. Further information, including staff turnover, can be found in nationally reported figures published by NHS Digital on the following link https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Breakdown of number of male and female directors, other senior managers and employees

The table below shows the gender breakdown in the Trust.

2020/21 data						
	Chief executive	**Executive directors**	**Non-executive directors**	**Other senior managers**	**All other employees**	**Total**
Female	0	2	2	3	815	821
Male	1	1	3	0	263	267
Total						**1088**

The Trust publishes an annual gender pay gap report and associated action plan. Reports are published on the Trust website and on the Cabinet Office website at gender-pay-gap.service.gov.uk

Sickness absence data

In line with national guidance, the table shows the sickness absence for the calendar year January to December 2021.

2020/21 Data		
Total full time equivalent staff years available	**Total days lost**	**Average number of days of sickness absence per full time equivalent employee**
911	9,872	6.7

Detailed information can be found at digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Employee benefits and staff numbers

Staff costs analysis

	Permanent £000	Other £000	2020/21 Total £000	2019/20 Total £000
Salaries and wages	42,957	-	**42,957**	40,093
Social security costs	4,178	-	**4,178**	3,936
Apprenticeship levy	193	-	**193**	182
Employer's contributions to NHS pension scheme	6,882	-	**6,882**	6,492
Pension cost - other	15	-	**15**	14
Temporary staff	-	1,055	**1,055**	2,810
Total gross staff costs	**54,225**	**1,055**	**55,280**	**53,527**
Recoveries in respect of seconded staff	-	-	**-**	(37)
Total staff costs	**54,225**	**1,055**	**55,280**	**53,490**
Of which:				
Costs capitalised as part of assets	94	340	**434**	598

Average number of employees (WTE basis)

	Permanent Number	Other Number	2020/21 Total Number	2019/20 Total Number
Medical and dental	159	10	**169**	165
Ambulance staff	-	-	**-**	-
Administration and estates	281	19	**300**	315
Healthcare assistants and other support staff	131	2	**133**	130
Nursing, midwifery and health visiting staff	199	26	**225**	232
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	58	5	**63**	65
Healthcare science staff	93	1	**94**	93
Social care staff	-	-	**-**	-
Other	-	-	**-**	-
Total average numbers	**921**	**63**	**984**	**1,000**
Of which:				
Number of employees (WTE) engaged on capital projects	2	2	**4**	9

Staff policies and actions applied during the financial year
During 2020/21, QVH continued to ensure all staff policies were systematically reviewed and updated to comply with changes in legislation, ensure that employment policies are in line with current good practice, and that applicants and employees are treated fairly and equitably. Key staff policies reviewed in 2020/21 included:

Policy / guidelines	Date ratified
Policy and procedure for exception reporting and work schedule review	**28/09/2020**
Alcohol, drug and substance misuse policy (fitness for work)	**28/09/2020**
Temporary staffing operational policy and management guidelines	**28/09/2020**
Disclosure and Barring Service (DBS) checks policy	**28/09/2020**
Supporting trans people guidelines	**28/09/2020**
Job planning for consultants and specialty and associate specialists doctors policy and procedure	**23/11/2020**
Policy for the management of acting-up and secondment	**22/02/2021**
Employment break scheme policy	**22/02/2021**
Policy for the checking of professional registration	**22/02/2021**
Flexible working and agile working policy	**22/03/2021**
Investigation policy	**22/03/2021**

Other actions taken in year included:

- Launch of the Stay Well team to support overall physical and psychological wellbeing during the pandemic
- Regular workforce briefings to the whole workforce to update and inform of changes to working arrangements and flexibilities in terms and conditions throughout the pandemic, for example annual leave, shielding and sickness and covid absence.

Policies applied during the financial year for giving full and fair consideration to applications for employment made by disabled persons, having regards to their particular aptitudes and abilities	QVH has a positive approach to applications from people with disabilities and makes adjustments where appropriate for interview and employment. The Trust is registered as a Disability Confident Employer, and the revised recruitment and selection training for managers covers in detail the required steps for supporting disabled candidates during the recruitment process.
Policies applied during the financial year for continuing the employment of, and arranging appropriate training for, employees who have become disabled persons during the period	The Trust continues to provide training sessions and ongoing support for managers and staff around disability, including a successful programme around mental health wellbeing. Our occupational health provider is very supportive of our disabled staff and is working with managers to ensure reasonable adjustments are given due consideration when recommended.

Policies applied during the financial year for training, career development and promotion of disabled employees	QVH works with individual staff who have disabilities, discussing their needs on a case-by-case basis. QVH is registered with the Disability Confident scheme and is committed to deliver against the NHS Employers recommended workforce disability equality standard within the next year.
Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees	We launched the Stay Well team initiative in partnership with the HR advisory service, organisational development and psychological therapy which has been very well utilised throughout the pandemic. During 2020/21 the chief executive continued to host regular staff briefing sessions. In 2020/21 the focus was primarily on the future plans for QVH and discussions in relation to potential merger The chief executive writes a blog which directly encourages comment from staff and continues to receive helpful feedback. A weekly staff newsletter provides an effective method of communication. Important news and developments are reported to staff in real time by email whenever necessary. The intranet site for staff, Qnet, was further enhanced to improve navigation and appearance and also includes new pages for clinical and medical education.
Actions taken in the financial year to consult with employees and their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests	QVH has good working relationships with its staff-side representatives and meets with them regularly to discuss the performance of the Trust in terms of its financial position, continuous improvement of care quality, workforce challenges and so on. These meetings continued virtually during the pandemic. Formal consultation with staff is driven through the joint consultation and negotiating committee comprising trade union and management representatives and the local negotiating committee involving managers and medical staff representatives and a British Medical Association representative.
Actions taken in the financial year to encourage the involvement of employees in the NHS Foundation Trust's performance	During 2020/20 a range of initiatives were successfully continued - albeit virtually or ensuring social distancing - including long service awards recognition and virtual staff awards. There are bi- monthly meetings of the hospital management team, with senior clinical leaders from across the Trust involved in strategy and decision making which was particularly beneficial through the pandemic. Whilst QVH has an open and supportive culture, it is important that we also provide other opportunities for

	staff to raise concerns safely without fear. The freedom to speak up guardian, elected by the workforce, continues to report directly to the chief executive in this role. Also, for the first time, with the support of the NHS England and Improvement regional team the Trust saw the election of two co-chairs for the first QVH BAME staff network.
Information on health and safety performance and occupational health	The Trust's health and safety group regularly receives reports highlighting any risks and how they are being addressed, with quarterly information on the support provided to staff through our occupational health and employee assistance providers. Our occupational health services have been provided by Cordell Health (previously the Robens Centre) since June 2019. Data on this is also included the workforce reports to board and committees of the board. The QVH staff physiotherapy self-referral service has continued to be successful in supporting individuals and preventing some workplace absences, although this has taken place virtually with telephone triage in most instances. The launch of the Stay Well team has been very successful in supporting the wellbeing of the whole workforce through a challenging time. Our employee assistance provider gives all staff access to a range of personal and professional support including confidential counselling and legal advice for both work related and non-work issues; stress management; advice to staff on injuries at work; access to an online well-being portal and 24-hour employee assistance programme which provides comprehensive advice, including legal advice.
Information on policies and procedures with respect to countering fraud and corruption	QVH takes fraud and corruption very seriously and regularly reviews processes to ensure that opportunities for fraud are minimised. The counter fraud team were fully consulted on the new investigation policy ratified during the year. There are also training sessions for staff and managers from the counter fraud team. These include training sessions for the recruitment team on right to work documentation and visual checks. We also act upon information provided by staff and encourage them to be open at all times where they feel their colleagues are not acting in the best interests of patients or the Trust. NHS Counter Fraud Authority training has been revised and an annual counter fraud survey undertaken. All board members received update training at a board seminar

The board of directors was provided with an annual report on workplace equality and diversity in November 2020, with progress marked against various equality initiatives and contractual requirements. This includes information on the gender pay gap, workforce WRES and WDES which are all published on the Trust's website. Progress against an action plan will be formally reported through the committee structure on a bi-annual basis.

Employee policy and service developments in the Trust require an equality impact assessment to encourage reflection on potential impacts to those with protected characteristics and human rights principles. Equality impact assessment is also embedded within the business case development process and guidance is provided for managers on carrying out these assessments.

The establishment of the QVH BAME network has been very positively received by the workforce and the co-chairs receive ongoing support, guidance and mentoring from the NHS England and Improvement regional team. Furthermore, the Trust has introduced BAME representation onto advisory appointment committees to bring a broader recruitment panel representation.

Retention and attraction challenges

During 2020/21 - whether due to or in spite of the pandemic - the Trust managed to maintain the positive gains made in relation to workforce KPIs, continuing to reap the benefits of the sustained attraction and retention campaign that began two years before. We continued the collaboration with two other NHS trusts for the overseas recruitment of nurses, including operating department practitioners, although it was suspended for several months due to the pandemic. Bank and agency usage dwindled during the first phase of the lockdown but started to rise again later in the year. Many banks shift were utilised for covid related activities such as staff and patient testing, setting up Optigene on site and the hospital hub vaccination centre. The Trust still has the highest number of substantive staff in post ever. The 2020 NHS staff survey results also remained stable with some areas of improvement during this time.

The Trust was proactive in its response to supporting staff to work from home during the pandemic if they could in line with national guidance. Around a third of the workforce were enabled to work in agile ways, including clinical staff setting up and running virtual clinics, transforming the way the Trust was able to support patients during such a challenging time.

A homeworking survey was undertaken after the first lockdown to learn from the experiences of staff who had working from home. This informed a revision and update to a new flexible and agile working policy and also confirmed that our approach to agile working had kept overall sickness absence rates – both covid and non-covid – below or close to the Trust KPI. Staff, particularly those shielding, also confirmed that the ability to work flexibly had reduced the likelihood of them needing to take sickness absence. The outcome of this was also consistent with themes from the 2020 staff survey.

Opportunities for education and learning were quickly transformed to virtual platforms, induction re-designed to allow us to still welcome new starters and e-learning promoted and rolled out. This led to mandatory and statutory KPIs being maintained throughout the whole period.

The Trust contributed as part of the ICS on the system response to the NHS People Plan and people promise launched in year. The Trust was well prepared for any impact of Brexit, offering surgeries to any of the workforce who required advice and guidance. It has had negligible impact on the direct workforce, but monitoring will continue.

Off payroll engagements
Use of off-payroll arrangements is subject to authorisation by the board of directors' nomination and remuneration committee.

In the financial year 2020/21 the Trust had no off-payroll arrangements.

All off-payroll engagements as of 31 March 2021, for more than £245 per day and that last for longer than six months	
Number of existing engagements as of 31 March 2021	0
Of which:	
Number that have existed for less than one year at the time of reporting	0
Number that have existed for between one and two years at the time of reporting	0
Number that have existed for between two and three years at the time of reporting	0
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	0
All existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.	Not applicable

All new off-payroll engagements, or those that reached six months in duration, between 1 April 2020 and 31 March 2021, for more than £245 per day and that last for longer than six months	
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2021	0
Of which: Number assessed as within the scope of IR35 Number assessed as not within the scope of IR35	 0 0
Number engaged directly (via PSC contracted to Trust) and are on the Trust's payroll	0
Number of engagements reassessed for the consistency/assurance purposes	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021	
Number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year	**0**
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and payroll engagements	**0**

Exit packages

Foundation trusts are required to disclose summary information on the use of exit packages agreed in the financial year. Staff exit packages are payable when the Trust terminates the employment of an employee before the normal retirement date or whenever an employee accepts voluntary redundancy in return for these benefits. In 2020/21 QVH made two payments in this category; a redundancy due to the end of a fixed term contract and a payment in lieu of notice within contractual terms.

2020/21 LIEU OF NOTICE		
Contractual Costs	**Agreement Number**	**Total Value of Agreements £000**
Voluntary Redundancies including early retirement	1	£3,990
Mutual agreed resignations (MARS)	0	
Early Retirements in the efficiency of the service	0	
Contractual payments in lieu of notice	1	£11,125
Exit payments following Employment Tribunals or court orders	0	
Non-contractual payments requiring HMT approval	0	
Total number of exit packages by type	2	£15,115
Total resource cost	£15,115	-

Trade union facility time disclosures

Queen Victoria Hospital NHS Foundation Trust
Trade Union Facility Time Regulations (2017)
2020/21 Report

Table 1
Relevant union officials

What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	*Full-time equivalent employee number*
4	*4*

Table 2
Percentage of time spent on facility time

How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	*Number of employees*
0%	
1-50%	4
51%-99%	
100%	

Table 3
Percentage of pay bill spent on facility time

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

First Column	*Figures*
Provide the total cost of facility time	£2,104
Provide the total pay bill	£53,791,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.004%

Table 4
Paid trade union activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: *(total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100*	0%

Staff survey results

Staff engagement

Improving staff engagement, engendering a sense of belonging, commitment and enthusiasm for our work and aligning the organisation's values is the most powerful and sustainable transformation we could ask for. Throughout a pandemic and period of significant pressure on the NHS, this has never been more important.

The engagement of staff is key in helping the Trust meet both current and future challenges. We involve staff wherever possible in decisions and communicate clearly with them to help maintain and improve staff morale especially through periods of uncertainty and change.

In 2018 and 2019 NHS staff surveys showed a step change in the score for recommending the Trust as a place to work – an improvement of 15% over two years. This stabilised for 2020.

We continue to implement the action plan from the work undertaken a part of the NHS Improvement retention improvement project, which has now become business as usual.

The goals laid out in our people and organisational development strategy clearly set out the Trust's vision, ambitions and plans for the development of QVH through our workforce. These goals are aligned to many of the themes in the 2020 staff survey:

People and organisational development goals	Staff survey themes
Engagement and communication	Staff engagement and team working
Attraction and retention	Morale
Health and wellbeing	Health and wellbeing and safe environment (bullying and harassment and violence)
Learning and education	Immediate managers
Talent and leadership	

Leadership for this work comes from the director of workforce and organisational development and progress against these goals is reported in workforce reports to the board and key committees under the Best Place to Work banner.

NHS staff survey
The NHS staff survey is conducted annually. From 2018 the results have been grouped to give scores in themed indicators. Team working was added as an additional theme in 2019. For the 2020 NHS staff survey, there were 10 themes compared to 11 in 2019. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those responses.

The number of questions in 2020 reduced from 90 to 78

For 2020, QVH took the decision to run a mixed mode survey due in part to the pandemic and the number of people working in agile ways. Specific areas were selected to receive either an online or paper survey. Paper surveys showed a 49% return rate compared with an online return rate of 62% once ineligibles were removed. The table below shows details on the response rate.

	Paper	Online	Total
Invited	248	811	1059
Blank	17	2	19
Completed	121	495	616
Excluded	0	0	0
Ineligible	1	2	3
Left organisation	0	7	7
Not returned	109	293	402
No further mailings	0	11	11
Opted out	0	0	0
Undelivered	0	1	1

In 2020, QVH surveyed 1,049 eligible staff compared to 1,009 in 2019. Of these, 616 responded. This equates to a 59% return rate, an increase from 58% the year before. The 2020 benchmarking group for acute specialist trusts has 14 organisations and showed a 56% return rate overall.

Benchmarking group comparator response rates:

	2016	2017	2018	2019	2020
Best	69.1%	62.0%	63.2%	69.6%	65.6%
QVH	55.5%	54.9%	52.2%	58.1%	58.7%
Median	49.7%	52.8%	52.8%	58.1%	56.1%
Worst	39.2%	38.0%	40.5%	46.3%	38.6%

Out of the 75 positive questions asked in the 2020 survey, three were significantly better, 62 had no significant difference and 10 were significantly worse than 2019 (see appendix 2 results).

The core questions around engagement which feed into the board reports are shown below. QVH saw a slight decrease of 1% for Q18a and Q18c but a 2% increase for Q18d.

Q	Description	2016	2017	2018	2019	2020
Q18a	Care of patients/service users is organisation's top priority	82%	81%	86%	88%	**87%**
Q18c	Would recommend organisation as place to work	62%	57%	62%	72%	**71%**
Q18d	If friend/relative needed treatment would be happy with standard of care provided by organisation	91%	88%	91%	92%	**94%**

The staff engagement scores are calculated from key questions in the survey, grouped into three categories. These are advocacy, involvement and motivation. The overall QVH engagement score for 2020 is 7.4%, a slight decrease of 0.1% from 2019.

A summary of QVH's most and least improved results from 2020 below will be looked at in greater detail across departments to identify if there are any trends in relation to specialties or particular staff groups.

2019	2020	Q	Most improved from last survey
37%	59%	11d	In last 3 months, have not come to work when not feeling well enough to perform duties
74%	84%	13a	Not experience harassment, bullying or abuse from patients/service users, their relatives or members of the public
70%	77%	17b	Would feel secure raising concerns about unsafe clinical practice
61%	67%	4f	Have adequate materials, supplies and equipment to do my work
36%	41%	11a	Organisation definitely takes positive action on health and wellbeing

2019	2020	Q	Least improved from last survey
67%	56%	4i	Team members often meet to discuss the team's effectiveness
71%	61%	11c	In the last 12 months, have not felt unwell due to work related stress
54%	46%	6c	Relationships at work are unstrained
63%	56%	6b	I have a choice in deciding how to do my work
43%	36%	9b	Communication between senior management and staff is effective

Summary details of local surveys and results

The staff friends and family test was suspended in 2020 due to the pandemic.

Areas of improvement

Of the 10 themes agreed for the 2020 survey, QVH's results show an improvement in 2 out of 10 themes, 3 remained at the same level and 5 decreased compared to 2019. The table below shows the statistical significance of the changes in the theme scores over the last year.

Theme	2019 score	2019 responses	2020 score	2020 responses	Statistically significant change?
Equality, diversion and Inclusion	**9.3**	**573**	**9.2**	**597**	**Not significant**
Health and wellbeing	**6.3**	**579**	**6.5**	**599**	**Not significant**
Immediate managers	**7.2**	**578**	**7.0**	**601**	**Not significant**
Morale	**6.6**	**569**	**6.4**	**591**	**Not significant**

Quality of care	**7.9**	**511**	**7.9**	**531**	**Not significant**
Safe environment – bullying and harassment	**8.2**	**575**	**8.4**	**569**	**Not significant**
Safe environment - violence	**9.8**	**577**	**9.8**	**597**	**Not significant**
Safety culture	**7.0**	**573**	**7.0**	**594**	**Not significant**
Staff engagement	**7.5**	**580**	**7.4**	**607**	**Not significant**
Team working	**7.0**	**572**	**6.5**	**602**	**Yes**

Key comparisons

When compared with our comparator group of 14 specialist acute trusts, our scores are average overall. QVH ranks above average on none, average on 8 and slightly below average on 2.

Theme	Best	QVH	Average	Worst
Equality, Diversion and Inclusion	**9.5**	**9.2**	**9.2**	**8.4**
Health & Wellbeing	**6.8**	**6.5**	**6.5**	**6.1**
Immediate Managers	**7.3**	**7.0**	**7.1**	**6.8**
Morale	**6.7**	**6.4**	**6.4**	**6.2**
Quality of Care	**8.1**	**7.9**	**7.9**	**7.6**
Safe Environment – bullying and harassment	**9.0**	**8.4**	**8.4**	**7.7**
Safe Environment - violence	**9.9**	**9.8**	**9.8**	**9.3**
Safety Culture	**7.5**	**7.0**	**7.0**	**6.9**
Staff Engagement	**7.6**	**7.4**	**7.4**	**7.1**
Team Working	**7.0**	**6.5**	**6.8**	**6.5**

When compared with the comparator group scores above, QVH can identify key results. QVH is average on the themes of equality, diversity and inclusion; health and wellbeing; immediate managers; morale; quality of care; bullying and harassment; violence; safety culture; and staff engagement. QVH scored below average on team working, and increased remote working due to the pandemic is likely to have impacted on this score. Results have been compared across providers in the local integrated care system and the general themes are consistent.

Questions/areas of improvement

A more in-depth analysis of the 2020 survey data highlights specific questions and areas where QVH has improved:

Theme	Q	Description	2019	2020
N/A	Q4f	Have adequate materials, supplies and equipment to do my work	61%	67%
2	Q5h	Satisfied with opportunities for flexible working patterns	56%	60%
6	Q7a	Satisfied with quality of care I give to patients/service users	88%	92%
2	Q11a	Organisation definitely takes positive action on health and well-being	36%	41%
2	Q11d	In last 3 months, have not come to work when not feeling well enough to perform duties	37%	59%
7	Q13a	Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	74%	84%
9	Q17b	Would feel secure raising concerns about unsafe clinical practice	70%	77%
1	Q26b	Disability: organisation made adequate adjustment(s) to enable me to carry out work	73%	82%

Areas for development

In addition to the specialist acute trust comparisons, further analysis identifies specific questions and areas where QVH needs to focus its actions for improvement:

Theme	Q	Description	2019	2020
4	Q4c	Involved in deciding changes that affect work	56%	50%
10	Q4h	Team members have a set of shared objectives	75%	69%
10	Q4i	Team members often meet to discuss the team's effectiveness	67%	56%
4	Q4j	I receive the respect I deserve from my colleagues at work	76%	70%
N/A	Q5d	Satisfied with amount of responsibility given	79%	74%
4	Q6b	I have a choice in deciding how to do my work	63%	56%
4	Q6c	Relationships at work are unstrained	54%	46%
3	Q8b	Immediate manager can be counted on to help with difficult tasks	76%	70%
3	Q8c	Immediate manager gives clear feedback on my work	66%	62%
3	Q8d	Immediate manager asks for my opinion before making decisions that affect my work	60%	55%
3	Q8e	Immediate manager supportive in personal crisis	81%	77%
3	Q9b	Communication between senior management and staff is effective	43%	36%
2	Q11c	In last 12 months, have not felt unwell due to work related stress	71%	61%
9	Q16d	Staff given feedback about changes made in response to reported errors/near misses/ incidents	58%	54%

Summary of themes

Based on the above findings, overall the Trust has managed to maintain largely positive survey results in comparison to the national picture in a challenging environment. There are a number of areas where QVH has made a significant improvement over the 2019 NHS Staff Survey which must remain a focus in order to continue enhancing staff experience, specifically:

- Health and well-being (people and organisational development strategy goal 3)
- Safe environment - bullying and harassment (people and organisational development strategy goal 3).

QVH will continue to triangulate key findings from the NHS staff survey report alongside the Picker report, people and organisational development strategy, and the stay/exit interviews to ensure we effectively listen and respond to the needs of staff. We will work closely with the co-chairs of the Black, Asian and Minority Ethnic (BAME) staff network with a focus on the experience of staff from a BAME background.

Over and above the primary areas identified in the survey, other areas that will be a focus for improvement include team working and team building.

With consideration to the overall results, it appears there may be a correlation between the impact of covid and the responses to some of the themes in the 2020 survey. The health and wellbeing theme improved and HR offered staff a range of resources and support through the Stay Well initiative. Themes that need improvement are where the impact of social distancing and remote working can be seen, such as team working, immediate managers, morale and staff engagement.

Summary of ongoing actions

Actions will be undertaken in collaboration with key stakeholders including business units, communications and colleagues in workforce and organisational development and learning and will include:

- Ongoing promotion of education, learning and development across virtual platforms and, as the year progresses, offering a more blended approach to learning
- Further promotion of our successful apprenticeship programmes across the Trust

- Continuing to promote and develop management and leadership opportunities in house and externally across the wider system
- Working with business units in relation to specific team interventions and staff survey themes
- Ongoing promotion of a range of wellbeing events
- Promotion of Trust benefits
  Monitoring the mover/leavers survey to get qualitative and quantitative data to inform future attraction and retention interventions.

Each locality will take responsibility for reviewing comparative data for 2019/20 to identify improvements and areas to focus on, including:

- Sharing results with their localities
- Seeking ideas to inform improvements
- Developing and implementing a joint/agreed action plan
- Sharing regular updates/outcomes on implementation with teams and senior management.

At a corporate level, initiatives include:

- Reviewing our approach to agile working on a longer term basis
- Reviewing staff survey data in relation to equality, diversity and inclusion and updating our action plan
- Involving the freedom to speak up guardian and BAME network co-chairs by sharing relevant and appropriate information to support their programmes of work
- Working with key theme trust leads on implementation of strategy and communications.

Expenditure on consultancy
During 2020/21, the Trust incurred consultancy costs of £31,500. This was for support to work on the strategic case for possible merger. The Sussex Health and Care Partnership funded the Trust for these costs in recognition of the need to secure a long term sustainable solution for the hospital.

3.4 NHS foundation trust code of governance disclosures

Statement

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

	Part of schedule A (see above)	**Relating to**	***Code of Governance* reference**	**Summary of requirement**
1.	2: Disclose	Board and Council of Governors	A.1.1	The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.
The schedule of matters reserved for the board of directors was updated in 2020/21 following a review of the Trust's standing orders and standing financial instructions and is published to the Trust's website. This suite of documents was implemented from 4 July 2020. The schedule includes a series of statements detailing the roles and responsibilities of the council of governors. Separate standing orders for the council of governors are in place. **The Trust's constitution and standing orders. (published to the Trust's website) provide the framework for decision making and delegation between the board of directors, council of governors and executive management team, including how any disagreements between the council of governors and the board of directors will be resolved.**				

2.	2: Disclose	Board, nomination committee(s) audit committee, remuneration committee	A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors. Part of this requirement is also contained within paragraph 2.22 as part of the directors' report.
A register of this information is at appendix 7.1.				
3.	2: Disclose	Council of governors	A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.
A register of this information is at appendix 7.2.				
4.	Additional requirement of NHS foundation trust annual reporting manual (FT ARM)	Council of governors	n/a	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.
A register of this information is at appendices 7.1 and 7.2.				
5.	2: Disclose	Board	B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.
A register of this information is at appendix 7.1.				

6.	2: Disclose	Board	B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS Foundation Trust.
Directors' biographies are included at appendix 7.3. The Trust considers that the board of directors remains balanced, complete, appropriate and compliant with the provisions of the NHS Foundation Trust Code of Governance and its own terms of authorisation.				
7.	Additional requirement of FT ARM	Board	n/a	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated
Details of the length of appointments of the non-executive directors are included at appendix 7.1. Paragraph 35 of the Trust's constitution sets out the criteria and process for termination of a non-executive director contract.				
8.	2: Disclose	Nominations committee(s)	B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.
See section 3.2.				
9.	Additional requirement of FT ARM	Nominations committee(s)	n/a	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.
Not applicable in 2020/21.				
10.	2: Disclose	Chair/council of governors	B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise and included in the next annual report.

A register of directors' interests is kept by the Trust and is available at any time on request from the deputy company secretary. This register is also included in full in the papers for meetings of the board of directors held in public.				
11.	2: Disclose	Council of governors	B.5.6	Governors should canvass the opinion of the Trust's members and the public, and for appointed governors the body they represent, on the NHS Foundation Trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.
Compliant: The QVH outlook for 2020/21 was presented at the annual general meeting and annual members meeting (AGM/AMM) held on 28 September 2020, to which all members were invited. Regular information on strategy and development is included in the Trust's newsletter for members and the general public and in email bulletins to members. The council of governors receives regular presentations by the chief executive and executive team, providing an overview of the national and local position to support informed discussion of forward plans.				
12.	Additional requirement of FT ARM	Council of governors	n/a	If, during the financial year, the governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)
Not applicable in 2020/21.				
13.	2: Disclose	Board	B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.

At its meeting in March 2021, the board considered an internal evaluation report which covered the collective performance of the board, the performance of its committees and the individual performance of its directors in addition to developmental opportunities throughout the year. The board was assured by this review that the Trust's governance arrangements remained fit for purpose. **The performance of the executive directors is assessed by the chief executive taking into account feedback sought from relevant members of staff and the board. The performance of the chief executive is assessed by the chair taking into account feedback sought from relevant members of staff and the board. The performance of the non-executive directors is assessed by the chair taking into account feedback sought from the executive directors and governors. The performance of the chair is assessed by the senior independent director in collaboration with the chair of the council of governors' appointments committee taking into account feedback sought from directors and governors, particularly the council's governor representatives to the board and its sub-committees.** **Processes for performance evaluation for directors and the chair continue to be refined on an annual basis to ensure input remains meaningful and, in 2020, the Trust adopted the new *Framework for conducting annual appraisals of NHS provider chairs*** **14.** 2: Disclose Board B.6.2 Where there has been external evaluation of the board and/or governance of the trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust. **Not applicable in 2020/21.** **15.** 2: Disclose Board C.1.1 The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the annual governance statement (within the annual report). See also FT ARM paragraph 2.95 **See the annual governance statement at section 3.7.** **16.** 2: Disclose Board C.2.1 The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls. **See the annual governance statement at section 3.7.**				

17.	2: Disclose	Audit committee/ control environment	C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.
In 2020/21 the Trust's internal audit function was provided by RSM Risk Assurance Services LLP. The purpose of internal audit is to provide the Trust board, via the audit committee, with an independent and objective opinion on risk management, internal control and governance arrangements. The scope of coverage in 2020/21 included: • **Research and development** • **Staff retention** • **Financial governance and control during covid** • **Conflict of interest** • **Referrals and waiting list management** • **Procurement and contract management** • **Risk management** • **Financial systems and payroll** • **GDPR – data security and protection (DSP) toolkit** • **Estates and facilities.**			
18.	2: Disclose	Audit committee/ council of governors	C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.
Not applicable in 2020/21.				

19.	2: Disclose	Audit committee	C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.

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

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

During 2020/21 the committee received reports from the Trust's internal and external auditors that provided the committee with a review of the Trust's internal control and risk management systems. The committee considered the key financial estimates when reviewing the financial statements.

In Q3, the committee undertook a review of its effectiveness and terms of reference. Its work programme was also reviewed and updated during the last quarter of the financial year to ensure it remained relevant and meaningful.

The internal auditor's opinion, based on the work performed to 31 March 2021 is that the organisation has an adequate and effective framework for risk management, governance and internal control. However further enhancements have been identified for the framework of risk management, governance and internal control to ensure it remains adequate and effective.

The external auditors did not provide non-audit services.

The main source of income for the Trust is the provision of healthcare services to the public under contracts with NHS commissioners, this has been affected in 2020/21 due to the financial funding regime to support the NHS through the pandemic. The Trust participates in the national agreement of balances exercise performed at months nine and twelve. The agreement of balances exercise identifies mismatches between receivable and payable balances recognised by the Trust and its commissioners and all differences are investigated by the finance team.

The Trust undertook a desk top valuation and impairment review exercise during 2020/21.

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

20.	2: Disclose	Board/ remuneration committee	D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.
Not applicable.				
21.	2: Disclose	Board	E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS Foundation Trust, for example through attendance at meetings of the council of governors, direct face-to-face contact and surveys of members' opinions and consultations.

Compliant: The board of directors uses a variety of methods to understand the views of governors:

- **In 2020/21 the lead governor was invited to attend all meetings of the board of directors including seminars, workshops and meeting sessions held in private. A requirement of this role is to provide feedback to governor colleagues to contribute to the council of governor's statutory duty to hold non-executive directors (NEDs) to account for the performance of the board of directors.**
- **Directors attend all meetings of the council of governors held in public. In 2020/21 council meeting agendas continued to be refined to provide more opportunities for non-executive directors to report to the council and for dialogue between NEDs and governors generally.**
- **The board invites a governor representative to attend meetings of its committees and feedback to governor colleagues. As the board committees are chaired by NEDs this facility gives more governors the opportunity to observe NEDs performing their duties as well as providing governors with wider insight into the operational activities of the Trust and corporate governance.**
- **The board of directors and council of governors have in place a document formalising principles of engagement between the council's governor representatives and the Trust's board-level structures and mechanisms. This underwent annual review at the council of governors meeting in January 2021.**
- **QVH's governor representative roles foster closer working relationships between governors and NEDs and provide more opportunities for governors to see NEDs at work on a regular basis. As a result, governors are better able to appraise the performance of the NEDs and hold them to account and NEDs are better informed of the views of governors and members.**

22.	2: Disclose	Board/membership	E.1.6	The board of directors should monitor how representative the NHS Foundation Trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.
The board recognises the challenges and limitations of establishing a representative membership base as it serves a large regional population with a range of specialist services and a smaller local population with a range of community services. Nonetheless, it ensures it continues to meet its responsibility to engage with stakeholders through various means, including the regular scrutiny of friends and family test and patient experience results. A QVH patient is invited to nearly every board meeting to describe their experience of care at the Trust.				
23.	2: Disclose	Membership	E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS Foundation Trust's website and in the annual report.
Members who wish to communicate with the directors or governors should contact the deputy company secretary on 01342 414200 or hilary.saunders1@nhs.net This information is also available from the Trust's website at: www.qvh.nhs.uk/board-of-directors and www.qvh.nhs.uk/council-of-governors-2				
24.	Additional requirement of FT ARM	Membership	n/a	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.

The Trust's members belong to either the public or staff constituency. Paragraphs 8 and 9 of the Trust's constitution set out eligibility criteria for membership of each constituency. As at 31 March 2021, the number of members within the public constituency was 7,766 and the staff constituency was 1,082. **The Trust's membership strategy was reviewed by the Trust and presented to members, governors and non-executive directors at the Trust's annual membership meeting on 28 September 2020.** **Additional information regarding membership of the QVH Foundation Trust can be found online at www.qvh.nhs.uk/for-members/**				
25.	Additional requirement of FT ARM (based on FReM requirement)	Board/council of governors	n/a	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS Foundation Trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report. See also ARM paragraph 2.22 as directors' report requirement.
A register of directors' and governors' interest is kept by the Trust and is available on the Trust's public website and may also be requested from the deputy company secretary.				
26.	6: Comply or explain	Board	A.1.4	The board should ensure that adequate systems and processes are maintained to measure and monitor the NHS Foundation Trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery
Compliant.				
27.	6: Comply or explain	Board	A.1.5	The board should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance
Compliant.				

28.	6: Comply or explain	Board	A.1.6	The board should report on its approach to clinical governance.
Compliant. The Trust's clinical governance group is responsible for: • **Ensuring that QVH meets its statutory duty of quality through clinical governance** • **Ensuring the best use of available resources for patients by establishing policies for effective clinical services** • **Identifying and instigating policy improvement from clinical audit and outcomes monitoring processes** • **Identifying and mitigating risks relating to the development and implementation of clinical policy.** **The group meets formally monthly and reports to the quality and governance committee of the board which, in turn, provides assurance to the full board of directors. The group is chaired by the medical director and its members include the director of nursing and quality; head of risk, clinical quality and patient safety; governance leads of clinical specialties; senior nurses; and service managers.**				
29.	6: Comply or explain	Board	A.1.7	The chief executive as the accounting officer should follow the procedure set out by NHS Improvement (Monitor) for advising the board and the council of governors and for recording and submitting objections to decisions.
Compliant.				
30.	6: Comply or explain	Board	A.1.8	The board should establish the constitution and standards of conduct for the NHS Foundation Trust and its staff in accordance with NHS values and accepted standards of behaviour in public life.
Compliant. The constitution was updated in January 2021 and published to the Trust's website. The Trust's standards of business conduct and behaviour policy was updated in 2020/21, approved by the Trust's audit committee and subsequently disseminated to all members of staff.				
31.	6: Comply or explain	Board	A.1.9	The board should operate a code of conduct that builds on the values of the NHS Foundation Trust and reflect high standards of probity and responsibility.
Compliant. See 30 above.				
32.	6: Comply or explain	Board	A.1.10	The NHS Foundation Trust should arrange appropriate insurance to cover the risk of legal action against its directors.
Compliant.				

33.	6: Comply or explain	Chair	A.3.1	The chairperson should, on appointment by the council of governors, meet the independence criteria set out in B.1.1. A chief executive should not go on to be the chairperson of the same NHS foundation trust.
Compliant.				
34.	6: Comply or explain	Board	A.4.1	In consultation with the council of governors, the board should appoint one of the independent non-executive directors to be the senior independent director.
Compliant. In consultation with the council of governors, the board appointed Gary Needle as senior independent director in October 2019.				
35.	6: Comply or explain	Board	A.4.2	The chairperson should hold meetings with the non-executive directors without the executives present.
Compliant. The chair has met with the non-executive directors on alternate weeks throughout 2020/21.				
36.	6: Comply or explain	Board	A.4.3	Where directors have concerns that cannot be resolved about the running of the NHS Foundation Trust or a proposed action, they should ensure that their concerns are recorded in the board minutes.
Not applicable in 2020/21.				
37.	6: Comply or explain	Council of governors	A.5.1	The council of governors should meet sufficiently regularly to discharge its duties.
Compliant.				
38.	6: Comply or explain	Council of governors	A.5.2	The council of governors should not be so large as to be unwieldy.
Compliant: The council of governors comprises 20 public members, three staff members and three stakeholder representatives, as established by paragraph 14 of the Trust's constitution.				
39.	6: Comply or explain	Council of governors	A.5.4	The roles and responsibilities of the council of governors should be set out in a written document.

Compliant. NHS England and Improvement (Monitor) publishes guides to the duties and legal obligations of foundation trust governors. General duties of the Trust's council of governors are included in provision 19 of the Trust's constitution.				
40.	6: Comply or explain	Council of governors	A.5.5	The chairperson is responsible for leadership of both the board and the council of governors but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive to their meetings and inviting attendance by other executives and non-executives, as appropriate.
Compliant. The chief executive, members of the executive management team and non-executive directors attend the public sessions of each quarterly meeting.				
41.	6: Comply or explain	Council of governors	A.5.6	The council of governors should establish a policy for engagement with the board of directors for those circumstances when they have concerns.
Compliant. Provision 52 of the Trust's constitution sets out provisions for disputes between the council of governors and board of directors.				
42.	6: Comply or explain	Council of governors	A.5.7	The council of governors should ensure its interaction and relationship with the board of directors is appropriate and effective.

The council of governors relies on several roles and functions to ensure its interaction and relationship with the board of directors is appropriate and effective. These include the role of the Trust chair as chair of both bodies; the roles of the director of communications and corporate affairs and the deputy company secretary as advisers to both bodies; the work of the governor steering group and appointments committee; and the role of the governor representatives to the board of directors and its sub-committees. **QVH has a long-standing practice of inviting governor representatives to attend the board and committee meetings (see item 21 above).** **The board of directors and council of governors have agreed a document formalising principles of engagement between the council's governor representatives and the Trust's board-level structures and mechanisms. This is reviewed on an annual basis.**				
43.	6: Comply or explain	Council of governors	A.5.8	The council of governors should only exercise its power to remove the chairperson or any non-executive directors after exhausting all means of engagement with the board.
Not applicable in 2020/21. Paragraph 35 of the Trust's constitution describes the process for removal of the chair and other non-executive directors.				
44.	6: Comply or explain	Council of governors	A.5.9	The council of governors should receive and consider other appropriate information required to enable it to discharge its duties.
Compliant.				
45.	6: Comply or explain	Board	B.1.2	At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent.
Compliant.				
46.	6: Comply or explain	Board/council of governors	B.1.3	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust.

Compliant. See provision 18 of the Trust's constitution.				
47.	6: Comply or explain	Nomination committee(s)	B.2.1	The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors.
Compliant. The board of directors' nomination committee is responsible for the identification and nomination of executive directors and the council of governors' appointments committee is responsible for identification and nomination of non-executive directors.				
48.	6: Comply or explain	Board/council of governors	B.2.2	Directors on the board of directors and governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence.
Compliant. The Trust's declaration of interests pro-forma for directors and governors also incorporates a fit and proper persons declaration. Declarations are made by all directors and governors accordingly with each submitting a self-assessment against the categories of person prevented from holding office. These declarations are updated on an annual basis.				
49.	6: Comply or explain	Nomination committee(s)	B.2.3	The nominations committee(s) should regularly review the structure, size and composition of the board and make recommendations for changes where appropriate.
Compliant.				
50.	6: Comply or explain	Nomination committee(s)	B.2.4	The chairperson or an independent non-executive director should chair the nominations committee(s).
Compliant.				
51.	6: Comply or explain	Nomination committee(s)/ council of governors	B.2.5	The governors should agree with the nominations committee a clear process for the nomination of a new chairperson and non-executive directors.
Compliant. See 47 above. Part of the remit of the council of governors' appointments committee is to oversee the appointment processes for the chair and non-executive directors, making recommendations in this regard to the council of governors.				

52.	6: Comply or explain	Nomination committee(s)	B.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist of a majority of governors.
Compliant. See 47 above.				
53.	6: Comply or explain	Council of governors	B.2.7	When considering the appointment of non-executive directors, the council of governors should take into account the views of the board and the nominations committee on the qualifications, skills and experience required for each position.
Compliant: The appointments committee's terms of reference state that before any appointment is made by the council of governors, it should evaluate the balance of skills, knowledge and experience of the non-executive directors and, in light of this evaluation, prepare a description of the role and capabilities required for a particular appointment.				
54.	6: Comply or explain	Council of governors	B.2.8	The annual report should describe the process followed by the council of governors in relation to appointments of the chairperson and non-executive directors.
Compliant. See 51 above.				
55.	6: Comply or explain	Nomination committee(s)	B.2.9	An independent external adviser should not be a member of or have a vote on the nominations committee(s).
Compliant.				
56.	6: Comply or explain	Board	B.3.3	The board should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity.
Not applicable in 2020/21.				
57.	6: Comply or explain	Board/council of governors	B.5.1	The board and the governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make.

Compliant. Papers for meetings of the board of directors and council of governors are available from the Trust's website. **In addition to meeting papers, the board of directors and council of governors receive regular briefings from the Trust, its regulators and its representative bodies to inform and provide context to the functions and decisions of the board and the council.** **The council of governors receives notification when papers for meetings of the board of directors are published and the meeting agenda, reports from the chair and chief executive are extracted from the papers and issued directly to governors. Governors have a facility to log general queries to non-executive directors and the Trust's executive management team. The log records the response to the queries so that they can be shared systematically with all governors to share information and learning across the council.** **Governor representatives to the board and its committees also submit personal reports to their colleagues in the company secretarial team's monthly update for governors.**				
58.	6: Comply or explain	Board	B.5.2	The board, and in particular non-executive directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis.
Compliant.				
59.	6: Comply or explain	Board	B.5.3	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the NHS Foundation Trust's expense, where they judge it necessary to discharge their responsibilities as directors.
Compliant.				
60.	6: Comply or explain	Board/committees	B.5.4	Committees should be provided with sufficient resources to undertake their duties.
Compliant.				
61.	6: Comply or explain	Chair	B.6.3	The senior independent director should lead the performance evaluation of the chairperson.

Compliant. The performance of the chair is assessed by the senior independent director in collaboration with the chair of the council of governors' appointments committee and in line with the new framework for conducting annual appraisals of NHS provider chairs. **See 13 above.**				
62.	6: Comply or explain	Chair	B.6.4	The chairperson, with assistance of the board secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as board members.
Compliant. The board of directors meet every other month for a seminar which gives a greater focus on strategy development and opportunities for board development. The board development programme has been shaped to ensure that it operates effectively and that the organisation is well led. The programme is the responsibility of the Trust chair who is supported in this task by the director of workforce and organisational development and the director of communications and corporate affairs.				
63.	6: Comply or explain	Chair/council of governors	B.6.5	Led by the chairperson, the council of governors should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities.
The collective performance of the council is reviewed every three years. The council's governor steering group agreed to a 12-month postponement of the review scheduled in 2021. **The Trust's bi-annual newsletter was deferred in 2020/21 although communications by email has continued with members who have provided the Trust with their email address.**				
64.	6: Comply or explain	Council of governors	B.6.6	There should be a clear policy and a fair process, agreed and adopted by the council of governors, for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council or has an actual or potential conflict of interest which prevents the proper exercise of their duties.
Compliant. The circumstances in which a governor may be disqualified or removed from the council of are set out in provision 18 of the Trust's constitution.				

65.	6: Comply or explain	Board/remuneration committee	B.8.1	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.
Not applicable in 2020/21.				
66.	6: Comply or explain	Board	C.1.2	The directors should report that the NHS Foundation Trust is a going concern with supporting assumptions or qualifications as necessary. See also ARM paragraph 2.16
Compliant. See section 2 – Going Concern.				
67.	6: Comply or explain	Board	C.1.3	At least annually and in a timely manner, the board should set out clearly its financial, quality and operating objectives for the NHS Foundation Trust and disclose sufficient information, both quantitative and qualitative, of the NHS Foundation Trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance.
Compliant. The board sets out clearly its financial quality and operating objectives for the Trust through board papers, published to the website. These include both quantitative and qualitative information on the Trust's business and operation. Clinical outcome data is also included in the annual quality account which will be published later this year.				

68.	6: Comply or explain	Board	C.1.4	a) The board of directors must notify NHSI/E and the council of governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS Foundation Trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS Foundation Trust. b) The board of directors must notify NHSI/E and the council of governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in: • the NHS Foundation Trust's financial condition; • the performance of its business; and/or • the NHS Foundation Trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS Foundation Trust.
Compliant.				
69.	6: Comply or explain	Board/audit committee	C.3.1	The board should establish an audit committee composed of at least three members who are all independent non-executive directors.
Compliant.				
70.	6: Comply or explain	Council of governors/audit committee	C.3.3	The council of governors should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors.
Compliant.				

71.	6: Comply or explain	Council of governors/audit committee	C.3.6	The NHS Foundation Trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS Foundation Trust.
Compliant.				
72.	6: Comply or explain	Council of governors	C.3.7	When the council of governors ends an external auditor's appointment in disputed circumstances, the chairperson should write to NHSI/E informing it of the reasons behind the decision.
Not applicable in 2020/21.				
73.	6: Comply or explain	Audit committee	C.3.8	The audit committee should review arrangements that allow staff of the NHS Foundation Trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.
Compliant. In 2020/21, RSM UK acted as providers of the Trust's local counter fraud specialist service. An annual work plan was agreed and delivery was overseen by the audit committee. Counter fraud policies and procedures are widely publicised for staff and are included as part of the new staff induction process. **Whistleblowing is the responsibility of the quality and governance committee. However, the audit committee is responsible for providing assurance that the whistleblowing process is fit for purpose and working effectively, as required by the board.** **The role of the freedom to speak up guardian is specifically aimed at staff and provides confidential advice and support in relation to concerns about patient safety. The role reports directly to the chief executive and the freedom to speak up guardian attends the board of directors meetings regularly throughout the year.**				
74.	6: Comply or explain	Remuneration committee	D.1.1	Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels.
Compliant.				
75.	6: Comply or explain	Remuneration committee	D.1.2	Levels of remuneration for the chairperson and other non-executive directors should reflect the time commitment and responsibilities of their roles.

Compliant. The council of governors' appointments committee undertakes an annual review ensuring that QVH remuneration reflects the time commitment and responsibilities of the roles and the need to attract, retain and motivate non-executive directors with the skills and experience to lead the Trust successfully, and is in line with national guidance.				
76.	6: Comply or explain	Remuneration committee	D.1.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination.
Not applicable in 2020/21.				
77.	6: Comply or explain	Remuneration committee	D.2.2	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments.
Compliant.				
78.	6: Comply or explain	Council of governors/ remuneration committee	D.2.3	The council of governors should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.
Compliant. Following publication of the remuneration survey by NHS Providers, the appointments' committee reviewed the remuneration and terms and conditions of the chair and non-executive directors and made recommendations in this regard to the council of governors at its public meeting on 28 September 2020.				
79.	6: Comply or explain	Board	E.1.2	The board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums.
Compliant.				

80.	6: Comply or explain	Board	E.1.3	The chairperson should ensure that the views of governors and members are communicated to the board as a whole.
Compliant. Responsibility for ensuring that the views of governors and members are communicated to the board as a whole is shared between the chair, the director of communications and corporate affairs and the lead governor.				
81.	6: Comply or explain	Board	E.2.1	The board should be clear as to the specific third-party bodies in relation to which the NHS Foundation Trust has a duty to co-operate.
Compliant: The board of directors recognises that co-operation and collaboration are key to the sustainability of the organisation. Engagement with stakeholders in our local community and in the NHS is strong, with QVH well represented in all key NHS forums. **QVH maintains collaborative and productive relationships with representatives of third parties and over the last year has considered and continued to develop relationships with, among others:** • **University Hospitals Sussex NHS Foundation Trust, with specific partnership work on clinical pathways** • **Surrey and Sussex Cancer Alliance and Kent and Medway Cancer Alliance** • **The Sussex Health and Care Partnership with executive directors and the Trust chair regularly participating in all of the associated working groups and meetings** • **The Kent and Medway STP, with links made at chief executive level and representation on the QVH partnership working board** • **NHS trusts which host QVH 'spoke' services across the south east.**				
82.	6: Comply or explain	Board	E.2.2	The board should ensure that effective mechanisms are in place to co-operate with relevant third-party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each.
Compliant. See 81 above.				

3.5 NHS Single Oversight Framework

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

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

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

Segmentation

NHS Improvement has placed the Trust in segment 2, the second highest category and QVH has not been subject to any enforcement actions. This segmentation reflects targeted support needs identified in finance and use of resources, and operational performance.

This segmentation information is the Trust's position as at 28 May 2021. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

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

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

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

In preparing the accounts and overseeing the proper use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and

- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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

Steve Jenkin
Chief Executive and Accounting Officer
10 June 2021

3.7 Annual governance statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Queen Victoria Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Queen Victoria Hospital NHS Foundation Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The board views risk management as a corporate responsibility, in line with the NHS Improvement 2017 Well Led Framework which requires the board to have effective systems and processes in place to mitigate and manage risk. The degree and rigour of oversight the board has over the Trust's capacity to handle risk is apparent at the public and private boards, committees of the board meetings and board seminars.

The Trust's risk management training programme has been reviewed and all Trust staff attend this mandatory session. A small number of staff have been trained to undertake serious incident investigations, supported by the head of risk and patient safety, which include identification of future risk and actions to minimise these risks.

The director of nursing and quality is the Trust's lead for risk, supported by the head of risk and patient safety and the head of quality and compliance.

The audit committee is responsible for oversight and scrutiny of the Trust's integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical). This includes review of all risk and control related disclosure statements; the underlying assurance processes, including the board assurance framework; policies for ensuring compliance with regulatory, legal and code of conduct requirements and any related reporting and self-certifications; policies and procedures for all work related to counter fraud and security.

The clinical governance group is responsible for the management and monitoring of clinical risk management in the organisation and reports into the quality and governance committee.

The Trust's quality and governance committee and finance and performance committee are chaired by non-executive directors and have delegated authority from the board to review and assess the level of assurance and ensure that effective systems and processes are in place for optimum risk management. The corporate risk register is divided between these two committees to allow robust review of the relevant risks for each committee.

At every public board meeting there is scrutiny of the board assurance framework, the corporate risk register and detailed director reports which contain key quality and safety, operational, financial and organisational details, exception reporting and a focus on safe staffing levels. There are also reports from the chairs of the committees of the board to update on the level of assurance the committees have about quality, safety, clinical effectiveness, patient experience, operational delivery and finance.

The non-executive directors are held to account by the council of governors, with the chair of each Board sub-committee presenting an assurance report to council of governors meetings and well as taking questions from governors.

The Trust learns from incidents internally and externally, reviewing national publications and investigations to

identify relevant recommendations and learning to be shared throughout the Trust. This is achieved by utilising the clinical governance system to support the dissemination of key issues to Trust staff including the board, clinical governance group and joint hospital governance meeting. This learning is also shared externally with our commissioners and regulators for additional scrutiny and assurance. All serious incident investigations are reviewed by the quality and governance committee and action plans are reviewed at the clinical governance group one year after the incident, for assurance that the actions completed are fully embedded in practice.

The risk and control framework

The board is assured, as recorded in the annual effectiveness review considered in March 2021, that an effective governance structure is in place to enable and support QVH to meet its strategic objectives and ensure compliance with regulatory requirements. The governance structures are fit for purpose and in line with best practice in the NHS and other sectors.

In July 2020, the board conducted an annual review of the standing orders and standing financial instructions, the reservation of powers and scheme of delegation, with further updates to the reservation of powers and scheme of delegation in January 2021.

A process is in place for the regular review of effectiveness and adequacy of board committees, including terms of reference and work plans. This programme supports the board's annual evaluation of its own performance. The process of board subcommittee reviews has resulted in minor changes to terms of reference and internal processes.

Foundation trust boards are required to undertake an external review of governance every five years to ensure that governance arrangements remain fit for purpose. During 2017/18 QVH appointed an external team to carry out this review. In each of the eight key lines of enquiry, QVH demonstrated areas of good practice as well as areas for improvement. The Trust continues to use internal processes and external best practice to review and strengthen governance.

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

- Public board meetings are held bimonthly. There are detailed reports which include all key national performance measures on quality, operational performance, finance and workforce. There is opportunity for robust challenge and debate about these reports and the way in which the directors work collaboratively in order to meet the Trust's key strategic objectives and provide leadership and oversight of the systems in place for care provision and service delivery. In addition to this governance process, the non-executive chair of each board committee presents a report to the board about the level of assurance and key items for approval or discussion. All actions are monitored via a board action log.
- The quality and governance committee and the finance and performance committee are sub committees of the board chaired by non-executive directors and receive detailed reports on quality, operational performance, finance and human resources and there is an opportunity for scrutiny and challenge by the membership. Both committees monitor completion of actions via a committee action log.
- The audit committee seeks additional assurance on risk management by commissioning internal and external audits as part of the audit work programme or in response to specific issues. It requires evidence that effective systems and processes are in place to mitigate and manage risk.
- The board assurance framework and corporate risk register are discussed at every public board meeting.
- NHS Improvement information and monitoring requests are responded to in a timely manner and the executive management team attend quarterly NHS Improvement performance reviews.
- Regular provider engagement meetings are held with the Care Quality Commission to ensure compliance with regulatory standards and compassionate care.

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

Equality impact assessments are integrated into core business. Each new or revised policy requires an equality impact assessment to be completed to ensure the Trust meets legislative requirements and does not

discriminate against protected characteristic groups. The equality impact assessment is completed by the manager writing the policy and signed off by their line manager prior to approval by the relevant ratifying committee.

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

The effectiveness of emergency planning, response and resilience (EPRR) and business continuity systems are assured through a number of mechanisms including tabletop exercises and lockdown drills, partnership working with commissioners and NHS England and peer review by the Local Health Resilience Partnership. The Trust has maintained an incident response throughout the covid pandemic. Due to the pandemic there was a 'light touch' national self-assessment. There are 55 core standards applicable to QVH and the Trust was fully compliant in 48 of these. Seven standards were rated as partial compliance and there is an action plan in place to address these areas.

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months as required by the *Managing Conflicts of Interest in the NHS* guidance.

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

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

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

The Board Assurance Framework, discussed at every meeting of the board, continues to recognise the long term financial sustainability of the Trust as a key risk. The Trust works to ensure economy, efficiency and effectiveness in a number of ways including robust planning, application of controls, performance monitoring and independent reviews.

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

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

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

The finance and performance committee receives monthly updates on programme performance whilst the quality and governance committee reviews plans to ensure there is no negative impact upon the quality of service provision and/or outcomes.

Information governance

The Trust regards any data breach extremely seriously and voluntarily reports significant breaches to the Information Commissioners Office, (ICO) as soon as it is made aware. This includes informing all data subjects involved, initiating a root cause analysis investigation, ensuring that the outcomes are formally assessed, lessons learned and actions monitored and completed.

- (20/07/20) In response to a freedom of information request from the media, the Trust sent information on staff antibody testing that accidentally contained a hidden data table revealing related personal data. This was identified immediately and reported to the ICO. All data subjects were informed. The data was subsequently permanently removed from the response and the ICO determined that no further action was required.
- (20/06/20) In response to a data subject access request, a copy set of health records were accidentally sent to the wrong recipient. The data subject was informed immediately once the Trust was made aware and the incident was reported to the ICO. The records were returned to the Trust safely. Following a formal internal investigation, a robust checking procedure was put in place and the ICO determined that no further action was required.

Data quality and governance
The Trust uses a range of tools and processes to bring together the correct, complete and valid data required to support sound decision making.

Previous data quality challenges have been addressed during 2020/21 through the use of a fully integrated data warehouse and supported by regular studies of data flows and processes and routine independent audits. QVH has invested in additional reporting tools to support the increased demand of local and national reporting requirements. The implementation of digital tools such as PowerBI have started to allow greater automation, reducing the risk of human error and allowing experienced staff to address more complex data quality issues due to the in-depth and near real-time reporting capabilities.

Working with other NHS partners, the Trust has established new reports and systems integrating new datasets, increasing the level of reliable intelligence that can be extracted from the data to support regional and national datasets.

Review of effectiveness

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

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

- Regular board review of the board assurance framework and risk registers, as well as regular assurance reports by the chairs of the two key board assurance sub-committees (finance and performance and quality and governance) and minutes from audit committee meetings. Key risks are fully debated and the board ensures actions are in place where necessary
- Board members receive monthly performance reports on:
    - safe staffing and quality of care
    - operational performance
    - financial performance
    - workforce
- The board receives regular information governance reports via sub-committees.
- The audit committee reviews findings from internal and external audit work and ensures links to the risk register and assurance framework are maintained
- An extensive programme of clinical audits assesses patient experience and measures the effectiveness of treatment provided, with action taken where indicated, to ensure high quality care with re-audit where necessary.
- The head of internal audit opinion has stated that the organisation has an adequate and effective framework for risk management, governance and internal control, recommending further enhancements which will be implemented by the Trust to ensure risk management, governance and internal control remain adequate and effective

- The quality and governance committee reviews feedback from external assessments on quality of service, including NHS Improvement, Healthwatch, Care Quality Commission, NHS Resolution and audit, as well as ensuring internal quality measures are regularly tested and standards are met.

Conclusion

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

Steve Jenkin
Chief Executive
10 June 2021

4 Auditor's report and certificate

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Queen Victoria Hospital NHS Foundation Trust ("the Trust") for the year ended 31 March 2021 which comprise the Trust Statement of Comprehensive Income, Statement of Financial Position, Trust Statement of Changes in Taxpayers Equity and Statements of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2021 and of the Trust's income and expenditure for the year then ended; and
- have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 and the Department of Health and Social Care Group Accounting Manual 2020/21.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Directors have prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Directors' conclusions, we considered the inherent risks to the Trust's business model and analysed how those risks might affect the Trust's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate;
- we have not identified, and concur with the Directors' assessment that there is not a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Trust's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Trust's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Reading Board and Audit, Risk and Assurance Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reviewing the Trust's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account the current financial regime, we performed procedures to address the risk of management override of controls and the risk of fraudulent revenue recognition, in particular the risk of incentive for revenue to be manipulated into the wrong period around the year end.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to year-end accruals. We consider this risk to be applicable to non-payroll and non-depreciation expenditure.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included duplicate journals, unexpected account pairings, unusual cash transactions, unexpected users and seldom used accounts.
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Inspecting transactions in the period prior to and following 31 March 2021 to verify revenue and expenditure had been recognised in the correct accounting period.
- Evaluating accruals posted as at 31 March 2021 and verifying accruals are appropriate and accurately recorded.

Identifying and responding to risks of material misstatement due to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors and other management (as required by auditing standards), and from inspection of the Trust's regulatory and legal correspondence and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

As the Trust is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The Trust is subject to laws and regulations that directly affect the financial statements including financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the Trust is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2020/21. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2020/21.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 73, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of their services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and the use of information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

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

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

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

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Queen Victoria Hospital NHS Foundation Trust for the year ended 31 March 2021 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.

Dean Gibbs
for and on behalf of KPMG LLP
Chartered Accountants
London

18 June 2021

5 Annual accounts 2020/21

Foreword to the accounts
These accounts for the year ended 31 March 2021 have been prepared by Queen Victoria Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Steve Jenkin
Chief Executive
10 June 2021

Statement of Comprehensive Income

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	3	70,786	69,052
Other operating income	4	14,365	3,347
Operating expenses	6, 8	(80,740)	(80,006)
Operating surplus/(deficit) from continuing operations		**4,411**	**(7,607)**
Finance income	11	1	25
Finance expenses	12	(127)	(249)
PDC dividends payable		(1,268)	(1,325)
Net finance costs		**(1,394)**	**(1,549)**
Other gains / (losses)	13	-	15
Surplus / (deficit) for the year		**3,017**	**(9,141)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(171)	(3,189)
Revaluations	17	842	4,159
Total comprehensive income / (expense) for the period		**3,688**	**(8,171)**

Statement of Financial Position

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	14	2,230	2,279
Property, plant and equipment	15	51,935	50,375
Receivables	19	227	227
Total non-current assets		**54,392**	**52,881**
Current assets			
Inventories	18	1,462	1,154
Receivables	19	4,140	8,543
Cash and cash equivalents	20	8,582	2,910
Total current assets		**14,184**	**12,607**
Current liabilities			
Trade and other payables	21	(10,544)	(11,792)
Borrowings	23	(893)	(7,332)
Provisions	25	(88)	(62)
Other liabilities	22	(431)	(437)
Total current liabilities		**(11,956)**	**(19,623)**
Total assets less current liabilities		**56,620**	**45,865**
Non-current liabilities			
Borrowings	23	(3,653)	(4,512)
Provisions	25	(908)	(881)
Total non-current liabilities		**(4,561)**	**(5,393)**
Total assets employed		**52,059**	**40,472**
Financed by			
Public dividend capital		21,005	13,106
Revaluation reserve		13,943	13,689
Income and expenditure reserve		17,111	13,677
Total taxpayers' equity		**52,059**	**40,472**

The notes on pages 89 to 124 form part of these accounts.

The accounts were approved by the Board on 07 June 2021 and are signed on the Board's behalf by:

Steve Jenkin
Chief Executive
10 June 2021

Statement of Changes in Equity for the year ended 31 March 2021

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020	**13,106**	**13,689**	**13,677**	**40,472**
Surplus/(deficit) for the year	-	-	3,017	**3,017**
Impairments	-	(171)	-	**(171)**
Revaluations	-	842	-	**842**
Public dividend capital received *	7,899	-	-	**7,899**
Other reserve movements	-	(417)	417	**(0)**
Taxpayers' and others' equity at 31 March 2021	**21,005**	**13,943**	**17,111**	**52,059**

* £6.3m of the Public Dividend Capital (PDC) received was conversion of revenue loans. The remaining £1.5m was capital PDC received in year.

Statement of Changes in Equity for the year ended 31 March 2020

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019	**12,249**	**13,142**	**22,395**	**47,786**
Surplus/(deficit) for the year	-	-	(9,141)	**(9,141)**
Impairments	-	(3,189)	-	**(3,189)**
Revaluations	-	4,159	-	**4,159**
Public dividend capital received	857	-	-	**857**
Other reserve movements	-	(423)	423	**-**
Taxpayers' and others' equity at 31 March 2020	**13,106**	**13,689**	**13,677**	**40,472**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating surplus / (deficit)		4,411	(7,607)
Non-cash income and expense:			
Depreciation and amortisation	6	3,560	3,445
Net impairments	7	(232)	397
Income recognised in respect of capital donations	4	(254)	(564)
(Increase) / decrease in receivables and other assets		5,020	1,461
(Increase) / decrease in inventories		(308)	122
Increase / (decrease) in payables and other liabilities		(1,450)	(131)
Increase / (decrease) in provisions		60	279
Net cash flows from / (used in) operating activities		**10,807**	**(2,598)**
Cash flows from investing activities			
Interest received		1	25
Purchase of intangible assets		(422)	(1,012)
Purchase of PPE		(3,583)	(2,702)
Sales of PPE		-	15
Receipt of cash donations to purchase assets		79	432
Net cash flows from / (used in) investing activities		**(3,925)**	**(3,242)**
Cash flows from financing activities			
Public dividend capital received		7,899	857
Movement on loans from DHSC		(7,169)	5,613
Capital element of finance lease rental payments		(80)	(78)
Interest on loans		(179)	(210)
Interest paid on finance lease liabilities		(4)	(5)
PDC dividend (paid)		(1,677)	(1,371)
Net cash flows from / (used in) financing activities		**(1,210)**	**4,806**
Increase / (decrease) in cash and cash equivalents		**5,672**	**(1,034)**
Cash and cash equivalents at 1 April		**2,910**	**3,944**
Cash and cash equivalents at 31 March	20.1	**8,582**	**2,910**

Notes to the Accounts

Note 1 Accounting policies and other information

1.1 Basis of Preparation
NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the NHS Foundation Trust (the Trust) shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020-21, issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board.

Where the DHSC Group Accounting Manual permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

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

1.2 Going concern
These accounts have been prepared on a going concern basis.

The Trust is required under International Accounting Standard 1 to undertake an assessment of the NHS Foundation Trust's ability to continue as a going concern. Due to the materiality of the financial position, the Board has carefully considered whether the accounts should be prepared on the basis of being a going concern.

The board considered that the definition of going concern in the public sector focuses on the expected continued provision of services by the public sector rather than organisational form. The financial statements of all NHS providers and clinical commissioning groups will be prepared on a going concern basis unless there are exceptional circumstances where the entity is being or is likely to be wound up without the provision of its services transferring to another entity in the public sector. More detail on the management assessment of going concern is provided in the annual report.

1.3 NHS Charitable Funds
The Trust is corporate trustee to the Queen Victoria Hospital NHS Trust Charitable Fund and as such has the power to govern its financial and operating policies so as to obtain benefits from its activities for itself, its patients and its staff. The income and assets of the charity are not considered to be material amounts in the context of the Trust's Accounts and are therefore not consolidated.

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

The Trust derives its income from the provision of healthcare, mainly in its capacity as a specialist provider of various forms of reconstructive surgery. All services are subject to the same policies, procedures and governance arrangements and operate in a common economic environment utilising shared resources. They are also subject to the same regulatory environment and standards set by external performance managers. Accordingly, the Trust operates one segment, 'The provision of healthcare'.

This is in line with management information used within the Trust for whom the chief decision maker is the Trust Board.

1.5 Revenue from contracts with customers
Where income is derived from contracts with customers, it is accounted for under IFRS 15.

The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

The Trust has exercised the practical expedients permitted by IFRS 15 para 121 in preparing the disclosure at note 4. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work completed to date is not disclosed.

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations.

At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts
The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21
The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the Trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at an Integrated Care System level. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)
In the comparative period (2019/20), the Trust's contracts with NHS commissioners included those where the Trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer.

For 2020/21 and 2019/20
Revenue from Research Contracts
Where research Contracts fall under IFRS15, revenue is recognised as and when performance obligations are satisfied. At contract inception, the Trust assesses the outputs promised in the research contract to identify, as a performance obligation, each promise to transfer either a distinct good or service, or a series of distinct goods or services that are substantially the same and have the same pattern of transfer. The Trust recognises revenue as these performance obligations are met, which may be at a point in time, or over time, depending upon the terms of the contract.

NHS injury cost recovery scheme
The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less

an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Revenue from sale of non-current assets
Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract. No income from the sale of non-current assets was recognised in 2020/21.

1.6 Other forms of Income
Grants and donations
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income
The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.7 Expenditure on Employee Benefits
Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension Costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the two NHS Pensions Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the Trust is taken as equal to the contributions payable to the scheme for the accounting period. The contributions are charged to the operating expenses as they became due.

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

A more detailed account of the NHS Pensions scheme is included at note 9

National Employees Savings Trust (NEST)
The Trust participates in the National Employees Savings Trust (NEST) scheme as an alternative to those employees who are not eligible to join the NHS Pension Scheme. This was part of the auto enrolment requirements introduced by the Government.
NEST is a defined contribution scheme with a phased employer contribution rate which was 3% for 2020/21. The rate remains at 3% from April 2021.

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

1.9 Property, plant and equipment
Recognition
Property, plant and equipment is capitalised where:

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

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

Subsequent Expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

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

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:
- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost, modern equivalent asset basis.
- Non operational properties, including surplus land, are carried at open market value.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

A full valuation of Land and Buildings was undertaken as at 31st March 2020 by professionally qualified, Royal Institute of Chartered Surveyors (RICS) registered, external Valuers Gerald Eve LLP. The valuation was undertaken on a modern equivalent asset, alternate site basis. For 2020/21 the same Valuers have been contracted to undertake a 'desktop exercise' to determine appropriate values for inclusion in the Accounts at 31st March 2021.

The Trust has entered into an agreement to sell approximately 1.5 hectares of surplus land which currently forms part of the hospital site. Because the whole site is valued on a modern equivalent asset, alternate site

basis, this land is not included in the valuation and is therefore considered to have no value for the purposes of these accounts.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

Land and buildings are held in the Statement of Financial Position at the revalued amounts less any subsequent accumulated depreciation and impairment losses.
IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which have been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

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

Impairments
At each financial year end, the Trust checks whether there is any indication that its property, plant and equipment or intangible assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

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

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

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

De-recognition
Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their fair value less costs to sell. Depreciation ceases to be charged and the assets are not revalued, except where the

'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

In 2020/21 this includes assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

Useful lives of property, plant and equipment
The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Freehold land is considered to have an infinite life and is not depreciated. Estimated useful lives for buildings are advised to the Trust by an independent valuation expert and currently range from five to forty eight years.

Estimated useful lives for plant, machinery and medical equipment are generally five, ten or fifteen years depending on the nature and likelihood of technical obsolescence. Information Technology equipment is generally given a life of five to twenty five years.

Finance-leased assets (including land), are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

1.10 Intangible assets
Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of Trust's business, or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.
Expenditure on research is not capitalised; it is recognised as an operating expense in the period in which it is incurred. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

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

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation and useful lives
Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits. In the case of software licences, estimated useful life is generally five years.

1.11 Inventories
Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first-in first-out (FIFO) method.

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

1.12 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.13 Financial assets and Financial Liabilities
Recognition
Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

Classification and measurement
Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost
Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash

equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income as a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses in respect of Trade Receivables are determined by reference to debt history and identified trends. Expected credit losses in respect of Injury Compensation Scheme receivables are calculated using the DHSC national average of claims not reaching payment of 22.43% (2019-20 21.79%).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

De-recognition
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

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

1.14 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

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

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the Statement of Financial Position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The trust as lessor
A lessor shall classify each of its leases as an operating or finance lease. A lease is classified as finance lease when the lease substantially transfers all the risks and rewards incidental to ownership of an underlying asset. Where substantially all the risks and rewards are not transferred, a lease is classified as an operating lease.

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

1.15 Provisions
The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount, as a result of a past event, for which it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised in the Statement of Financial Position is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2021.

Early retirement provisions are discounted using HM Treasury's pension discount rate of negative 0.95% (2019-20: negative 0.50%) in real terms.

All general provisions are subject to four separate discount rates according to the expected timing of cash flows from the Statement of Financial Position date:

- A nominal short-term rate of minus 0.02% (2019-20: positive 0.51%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 0.18% (2019-20: 0.55%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
- A nominal long-term rate of 1.99% (2019-20: 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
- A nominal very long-term rate of 1.99% (2019-20: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

1.16 Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust.
The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 25.2 but is not recognised in the Trust's accounts.

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

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

Contingent liabilities are not recognised, but are disclosed, unless the probability of a transfer of economic benefits is remote. The Trust has no contingent assets or liabilities to disclose for 2020/21.

Contingent liabilities are defined as:

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

1.19 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.20 Value added tax

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

1.21 Corporation tax

Section 148 of the Finance Act 2004 amended S519A of the Income and Corporation Taxes Act 1988 to provide power to the treasury to make certain non-core activities of Foundation Trusts potentially subject to corporation tax.

In determining if an activity is likely to be taxable, a three-stage test may be employed:

- Is the activity an authorised activity related to the provision of core healthcare?

The provision of goods and services for purposes related to the provision of healthcare authorised under Section 14(1) of the Health and Social Care Act 2003 (HSCA) is not treated as a commercial activity and is therefore tax exempt.

- Is the activity actually or potentially in competition with the private sector?

Trading activities undertaken in house which are ancillary to core healthcare activities are not entrepreneurial in nature and not subject to tax. A trading activity that is capable of being in competition with the wider private sector will be subject to tax.

- Are the annual profits significant?

Only significant trading activity is subject to tax. Significant is defined as annual taxable profits of £50,000 per trading activity.

The majority of the Trust's activities are related to core healthcare and are not subject to tax. Where trading activities are undertaken that are commercial in nature, they are considered insignificant with profits per activity below the £50,000 tax threshold.
No corporation tax is currently incurred by the Trust.

1.22 Climate Change Levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

1.23 Foreign exchange
The functional and presentational currency of the Trust is sterling.

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

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:
• monetary items are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

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

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

1.24 Third party assets
Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.
Amounts held by the Trust at the balance sheet date were negligible.

1.25 Losses and Special Payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.
The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.26 Gifts
Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.27 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

1.28 Standards, amendments and interpretations in issue but not yet effective or adopted
IFRS 16 Leases
IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below.

For those recognised in the statement of financial position the standard also requires the re-measurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The Trust does not expect any material impact of applying IFRS in 2022/23 on the opening statement of financial position and the in-year impact on the Statement of Comprehensive Income and capital additions. This is because the only current material lease is already accounted for as a finance lease.

Other standards, amendments and interpretations
IFRS 17 Insurance Contracts - Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted.

1.29 Critical judgements in applying accounting policies
The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:
For 2020/21 the Trust has identified the following critical judgements that are required to be disclosed under IAS1 paragraph 122.

- **Going Concern**
  The financial statements have been prepared on a going concern basis as set out in note 1.2. In preparing the financial statements the directors have considered the Trust's overall financial position and expectation of future contractual income and cost improvements.

- **Valuation of Land and Buildings**
  The Trust has applied the concept of Modern Equivalent Asset (MEA) to estimate the valuation of its property assets, as applicable, under the guidance of the DHSC GAM and independent professional valuers. This may result in impairment costs or reversals falling to be recognised in reserves or the income and expenditure statement as appropriate.

- **Charitable Funds**
  The Trust continues to make the judgement that the Charitable Funds are not material for the Trust and have not been consolidated.

1.30 Sources of estimation uncertainty
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- **Valuation of land and buildings £43,276,000 (2019/20 £42,828,000)**
  This is the most significant estimate in the accounts and is based on the professional judgement of the Trust's independent valuer with extensive knowledge of the physical estate and market factors. The value does not take into account potential future changes in market value which cannot be predicted with any certainty.

- **Accruals of Income**

The major income streams derive from the treatment of patients or from funding provided by government bodies and can be predicted with reasonable accuracy. Provisions are made where there is doubt about the likelihood of the Trust actually receiving the income due. See note 19. For 2020/21 the majority of income was provided on a block contract arrangement reducing the risk for this year (see note 3 for further details).

- **Accruals of Expenditure**

Where goods or services have been received by the Trust but have not been invoiced at the end of the financial year, estimates are based on the best information available at the time, and where possible, on known prices and volumes. See note 21.

- **Provisions for Early retirements**

The Trust makes additional pension contributions in respect of a number of staff who have retired early from the service. Provisions have been made for these contributions, based on information from the NHS Pensions Agency. See note 25.

Note 2 Operating Segments

The Trust operates a single segment, the provision of healthcare

	2020/21 £000	2019/20 £000
Income	85,151	72,399
Segment surplus (deficit)	3,017	(9,141)
Segment net assets	52,059	40,472

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.5

Note 3.1 Income from patient care activities (by nature)	**2020/21 £000**	**2019/20 £000**
Eyes	7,314	6,595
Oral	13,705	12,358
Plastics	33,375	30,095
Sleep	5,631	5,078
Other	10,761	14,926
Total	**70,786**	**69,052**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2020/21 £000**	**2019/20 £000**
NHS England *	25,732	25,376
Clinical commissioning groups	42,326	40,289
Other NHS providers	1,765	1,211
Non-NHS: private patients	190	188
Non-NHS: overseas patients (chargeable to patient)	31	95
Injury cost recovery scheme **	236	291
Non NHS: other	506	1,602
Total income from activities	**70,786**	**69,052**

Additional note reference note 3 (above)

As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year. For income from patient care activities (source) income has been apportioned as per 19/20 income

*The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts. £2,097,000 has been included in the NHS England line (2019/20 £1,977,000)

** Injury Cost Recovery scheme is income received through the NHS injury scheme from insurance companies in relation to the treatment of patients who have been involved in road traffic accidents. It is subject to a provision for impairment of receivables of 22.43% (2019/20 21.79%) to reflect expected rates of recovery

Commissioner Requested Services

Within the 2020/21 financial statements, management have taken the view that commissioner requested services are those which are provided for the healthcare of NHS patients. Of the total income reported above, £70,565,000 (2019/20
£68,769,000) was derived from the provision of commissioner requested services, being all income except that associated with private and overseas patients.

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2020/21 £000	2019/20 £000
Income recognised this year	31	95
Cash payments received in-year	23	11
Amounts added to provision for impairment of receivables	79	2

Note 4 Other operating income

	2020/21		
	Contract income £000	Non-contract income £000	Total £000
Research and development	218	-	**218**
Education and training	1,640	-	**1,640**
Non-patient care services to other bodies	5,543	-	**5,543**
Reimbursement and top up funding	4,394	-	**4,394**
Receipt of capital grants and donations	-	254	**254**
Charitable and other contributions to expenditure	-	2,087	**2,087**
Other income	229	-	**229**
Total other operating income	**12,024**	**2,341**	**14,365**

	2019/20		
	Contract income £000	Non-contract income £000	Total £000
Research and development	325	-	**325**
Education and training	1,600	-	**1,600**
Non-patient care services to other bodies	111	-	**111**
Reimbursement and top up funding	-	-	**-**
Receipt of capital grants and donations	-	564	**564**
Charitable and other contributions to expenditure	-	-	**-**
Other income	747	-	**747**
Total other operating income	**2,783**	**564**	**3,347**

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2020/21 £000	2019/20 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	175	69
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

Note 5.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2021 £000	31 March 2020 £000
within one year	-	-
after one year, not later than five years	-	-
after five years	-	-
Total revenue allocated to remaining performance obligations	**-**	**-**

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 6 Operating expenses

	2020/21	2019/20
	£000	£000
Purchase of healthcare from non-NHS and non-DHSC bodies	181	1,112
Staff and executive directors costs	54,625	52,572
Remuneration of non-executive directors	113	109
Supplies and services - clinical (excluding drugs costs)	12,319	11,984
Supplies and services - general	707	731
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	1,139	1,429
Inventories written down	236	-
Consultancy costs	32	214
Establishment	771	822
Premises	4,339	3,456
Transport (including patient travel)	335	567
Depreciation on property, plant and equipment	3,193	3,157
Amortisation on intangible assets	367	288
Net impairments	(232)	397
Movement in credit loss allowance: contract receivables / contract assets	54	488
Change in provisions discount rate(s)	36	58
Audit fees payable to the external auditor		
audit services- statutory audit *	71	65
other auditor remuneration (external auditor only)	-	-
Internal audit costs	79	105
Clinical negligence	838	788
Legal fees	29	11
Insurance	44	22
Research and development	221	320
Education and training	100	150
Early retirements	-	30
Car parking & security	241	219
Hospitality	-	3
Losses, ex gratia & special payments	-	8
Other services, eg external payroll	134	171
Other	768	730
Total	**80,740**	**80,006**

Notes:

External Audit: The contract signed on 25/01/2017 states that the liability of KPMG, its members, partners and staff (whether in contract, negligence or otherwise) shall in no circumstances exceed £1,000,000 aside from where the liability cannot be limited by law. This is in aggregate in respect of all services.

* External audit fees for the statutory audit of financial statements 2020-21 was £59,435 exclusive of VAT (2019/20
£54,435)

Note 7 Impairment of assets

	2020/21	2019/20
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	(232)	397
Total net impairments charged to operating surplus / deficit	**(232)**	**397**
Impairments charged to the revaluation reserve	171	3,189
Total net impairments	**(61)**	**3,586**

Note 8 Employee benefits

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	42,957	40,093
Social security costs	4,178	3,936
Apprenticeship levy	193	182
Employer's contributions to NHS pensions	6,882	6,492
Pension cost - other	15	14
Temporary staff (including agency)	1,055	2,810
Total gross staff costs	**55,280**	**53,527**
Recoveries in respect of seconded staff	-	(37)
Total staff costs	**55,280**	**53,490**
Of which		
Costs capitalised as part of assets	434	598
Total Staff Costs Excluding capitalised costs	**54,846**	**52,892**

*The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts. £2,097,000 has been included in the NHS England line (2019/20 £1,977,000)

More detailed staff disclosures may be found in the Annual Report

Note 8.1 Retirements due to ill-health

During 2020/21 there was 1 early retirement from the Trust agreed on the grounds of ill-health (1 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £30k (£12k in 2019/20).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between
formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

National Employees Savings Trust (NEST)

The Trust participates in the National Employees Savings Trust (NEST) scheme as an alternative to those employees who are not eligible to join the NHS Pension Scheme. This was part of the auto enrolment requirements introduced by the Government.

NEST is a defined contribution scheme with a phased employer contribution rate which was 3% for 2020/21. The rate remains at 3% from April 2021.

Note 10 Operating leases

Note 10.1 Queen Victoria Hospital NHS Foundation Trust as a lessor

The Trust has no significant operating leases to disclose for 2020/21

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2020/21 £000	2019/20 £000
Interest on bank accounts	1	25
Total finance income	**1**	**25**

Note 12.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2020/21 £000	2019/20 £000
Interest expense:		
Loans from the Department of Health and Social Care	130	247
Finance leases	4	5
Interest on late payment of commercial debt	-	-
Total interest expense	**134**	**252**
Unwinding of discount on provisions	(7)	(3)
Total finance costs	**127**	**249**

Note 13 Other gains / (losses)

	2020/21 £000	2019/20 £000
Gains on disposal of assets	-	15
Total gains / (losses) on disposal of assets	**-**	**15**

Note 14.1 Intangible assets - 2020/21

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2020 - brought forward	**2,912**	**1,126**	**4,038**
Additions	242	180	**422**
Reclassifications	1,078	(1,078)	**-**
Disposals / derecognition	-	(104)	**(104)**
Valuation / gross cost at 31 March 2021	**4,232**	**124**	**4,356**
Amortisation at 1 April 2020 - brought forward	**1,759**	**-**	**1,759**
Provided during the year	367	-	**367**
Amortisation at 31 March 2021	**2,126**	**-**	**2,126**
Net book value at 31 March 2021	**2,106**	**124**	**2,230**
Net book value at 1 April 2020	**1,153**	**1,126**	**2,279**

Note 14.2 Intangible assets - 2019/20

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2019	**2,625**	**401**	**3,026**
Additions	74	938	**1,012**
Reclassifications	213	(213)	**-**
Valuation / gross cost at 31 March 2020	**2,912**	**1,126**	**4,038**
Amortisation at 1 April 2019	**1,471**	**-**	**1,471**
Provided during the year	288	-	**288**
Amortisation at 31 March 2020	**1,759**	**-**	**1,759**
Net book value at 31 March 2020	**1,153**	**1,126**	**2,279**
Net book value at 1 April 2019	**1,154**	**401**	**1,555**

Note 15.1 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	**3,960**	**47,458**	**625**	**16,036**	**7,637**	**75,716**
Additions	-	729	436	1,679	1,110	**3,954**
Impairments	-	(209)	-	-	-	**(209)**
Reversals of impairments	178	92	-	-	-	**270**
Revaluations	142	700	-	-	-	**842**
Reclassifications	-	210	(608)	-	398	**-**
Disposals / derecognition	-	-	(104)	(548)	-	**(652)**
Valuation/gross cost at 31 March 2021	**4,280**	**48,980**	**349**	**17,167**	**9,145**	**79,921**
Accumulated depreciation at 1 April 2020 - brought forward	**-**	**8,590**	**-**	**13,179**	**3,572**	**25,341**
Provided during the year	-	1,394	-	924	875	**3,193**
Disposals / derecognition	-	-	-	(548)	-	**(548)**
Accumulated depreciation at 31 March 2021	**-**	**9,984**	**-**	**13,555**	**4,447**	**27,986**
Net book value at 31 March 2021	**4,280**	**38,996**	**349**	**3,612**	**4,698**	**51,935**
Net book value at 1 April 2020	**3,960**	**38,868**	**625**	**2,857**	**4,065**	**50,375**

Note 15.2 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019	**5,990**	**43,600**	**391**	**15,083**	**6,738**	**71,802**
Additions	-	778	808	953	813	**3,352**
Impairments	(2,030)	(2,221)	-	-	-	**(4,251)**
Reversals of impairments	-	665	-	-	-	**665**
Revaluations	-	4,159	-	-	-	**4,159**
Reclassifications	-	477	(563)	-	86	**-**
Disposals / derecognition	-	-	(11)	-	-	**(11)**
Valuation/gross cost at 31 March 2020	**3,960**	**47,458**	**625**	**16,036**	**7,637**	**75,716**
Accumulated depreciation at 1 April 2019	**-**	**7,109**	**-**	**12,191**	**2,883**	**22,184**
Provided during the year	-	1,481	-	988	688	**3,157**
Disposals / derecognition	-	-	-	-	-	**-**
Accumulated depreciation at 31 March 2020	**-**	**8,590**	**-**	**13,179**	**3,572**	**25,341**
Net book value at 31 March 2020	**3,960**	**38,868**	**625**	**2,857**	**4,065**	**50,375**
Net book value at 1 April 2019	**5,990**	**36,491**	**391**	**2,892**	**3,855**	**49,618**

Note 15.3 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021						
Owned - purchased	4,280	35,163	349	2,616	4,676	**47,084**
Finance leased	-	1,909	-	-	-	**1,909**
Owned - donated/granted	-	1,924	-	996	22	**2,942**
NBV total at 31 March 2021	**4,280**	**38,996**	**349**	**3,612**	**4,698**	**51,935**

Note 15.4 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020						
Owned - purchased	3,960	34,835	598	1,748	4,054	**45,195**
Finance leased	-	1,939	-	-	-	**1,939**
Owned - donated/granted	-	2,094	27	1,109	11	**3,241**
NBV total at 31 March 2020	**3,960**	**38,868**	**625**	**2,857**	**4,065**	**50,375**

Note 16 Donations of property, plant and equipment

The League of Friends of the Queen Victoria Hospital and the Queen Victoria NHS Trust Charitable Fund donated capital items with a combined value of £79,000. The DHSC donated diagnostic equipment valued at £175,000 as part of the response to the Covid-19 pandemic.

Note 17 Revaluations of property, plant and equipment

Land and Buildings were revalued as at 31st March 2021 by professionally qualified, Royal Institute of Chartered Surveyors (RICS) registered, external valuers Gerald Eve LLP (see note 1.9). The valuation took account of changes in market values and work carried out by the Trust since the previous valuation as at 31 March 2020. The remaining useful lives of buildings were also reviewed taking account of the passage of time and maintenance and enhancements carried out by the Trust.

The Trust has entered into an agreement to sell approximately 1.5 hectares of surplus land which currently form part of the hospital site. Because the whole site is valued on a modern equivalent asset, alternate site basis, this land is not included in the valuation and is therefore considered to have no value for the purposes of these accounts.

Note 18 Inventories

	31 March 2021 £000	31 March 2020 £000
Drugs	148	194
Consumables	1,314	960
Total inventories	**1,462**	**1,154**

Inventories recognised in expenses for the year were £4,625k (2019/20: £9,927k). Write-down of inventories recognised as expenses for the year were £236k (2019/20: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £2,087k of items purchased by DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 19.1 Receivables

	31 March 2021 £000	31 March 2020 £000
Current		
Contract receivables *	3,921	8,746
Allowance for impaired contract receivables / assets	(1,081)	(1,241)
Prepayments (non-PFI)	476	645
PDC dividend receivable	430	21
VAT receivable	99	98
Other receivables	295	274
Total current receivables	**4,140**	**8,543**
Non-current		
Other receivables **	227	227
Total non-current receivables	**227**	**227**
Of which receivable from NHS and DHSC group bodies:		
Current	2,892	5,942
Non-current	227	227

* The majority of trade was with Clinical Commissioning Groups (CCGs) and NHS England as commissioners for NHS patient care services. Both were funded by Government to buy NHS patient care services so no credit scoring is deemed to be necessary

** The provision for the cost for the clinicians pension tax scheme is offset with an associated future funding stream

Note 19.2 Allowances for credit losses

	2020/21	2019/20
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 April - brought forward	**1,241**	**753**
New allowances arising	627	784
Reversals of allowances	(573)	(296)
Utilisation of allowances (write offs)	(214)	-
Allowances as at 31 Mar 2021	**1,081**	**1,241**

Note 20.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2020/21	2019/20
	£000	£000
At 1 April	**2,910**	**3,944**
Net change in year	5,672	(1,034)
At 31 March	**8,582**	**2,910**
Broken down into:		
Cash at commercial banks and in hand	264	402
Cash with the Government Banking Service	8,318	2,508
Total cash and cash equivalents	**8,582**	**2,910**

Note 20.2 Third party assets held by the trust

Queen Victoria Hospital NHS Foundation Trust held NIL cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the Trust has no beneficial interest.

Note 21.1 Trade and other payables

	31 March 2021 £000	31 March 2020 £000
Current		
Trade payables	2,764	6,160
Capital payables	1,338	1,142
Accruals	4,274	2,450
Social security costs	617	594
Other taxes payable	580	519
Other payables	971	927
Total current trade and other payables	**10,544**	**11,792**

Note 22 Other liabilities

	2021 £000	2020 £000
Current		
Deferred income: contract liabilities	202	207
Deferred grants	229	230
Total other current liabilities	**431**	**437**

Note 23 Borrowings

	31 March 2021 £000	31 March 2020 £000
Current		
Loans from DHSC	813	7,253
Obligations under finance leases	80	79
Total current borrowings	**893**	**7,332**
Non-current		
Loans from DHSC	3,489	4,267
Obligations under finance leases	164	245
Total non-current borrowings	**3,653**	**4,512**

In 2020/21 £6,391,000 of loans were converted to Public Dividend Capital (See SOCITE)

Note 23.1 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC £000	Finance leases £000	Total £000
Carrying value at 1 April 2020	**11,520**	**324**	**11,844**
Cash movements:			
Financing cash flows - payments and receipts of principal	(7,169)	(80)	**(7,249)**
Financing cash flows - payments of interest	(179)	(4)	**(183)**
Non-cash movements:			
Additions	-	-	**-**
Application of effective interest rate	130	4	**134**
Carrying value at 31 March 2021	**4,302**	**244**	**4,546**

Note 23.2 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC £000	Finance leases £000	Total £000
Carrying value at 1 April 2019	**5,869**	**-**	**5,869**
Cash movements:			
Financing cash flows - payments and receipts of principal	5,613	(78)	**5,535**
Financing cash flows - payments of interest	(210)	(5)	**(215)**
Non-cash movements:			
Additions	-	402	**402**
Application of effective interest rate	248	5	**253**
Carrying value at 31 March 2020	**11,520**	**324**	**11,844**

Note 24 Finance leases

Note 24.1 Queen Victoria Hospital NHS Foundation Trust as a lessee

Obligations under finance leases where the Trust is the lessee.

	31 March 2021 £000	31 March 2020 £000
Gross lease liabilities	**248**	**324**
of which liabilities are due:		
- not later than one year;	84	79
- later than one year and not later than five years;	164	245
- later than five years.	-	-
Finance charges allocated to future periods	(4)	-
Net lease liabilities	**244**	**324**
of which payable:		
- not later than one year;	80	79
- later than one year and not later than five years;	164	245
- later than five years.	-	-

Note 25.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2020	**32**	**658**	**26**	**227**	**943**
Change in the discount rate	-	36	-	-	**36**
Arising during the year	-	28	11	22	**61**
Utilised during the year	(6)	(22)	-	-	**(28)**
Reversed unused	(3)	-	(6)	-	**(9)**
Unwinding of discount	-	(7)	-	-	**(7)**
At 31 March 2021	**23**	**693**	**31**	**249**	**996**
Expected timing of cash flows:					
- not later than one year;	6	29	31	**22**	**88**
- later than one year and not later than five years;	17	114	-	**-**	**131**
- later than five years.	(0)	550	-	**227**	**777**
Total	**23**	**693**	**31**	**249**	**996**

The provisions for pensions represent the discounted value of annual payments made to the NHS Pensions Agency calculated on an actuarial basis

Legal claims are relating to third party and employer's liabilities. Where the case falls within the remit of the risk pooling schemes run by NHS Resolution (formerly NHS Litigation authority), the Trust's liability is limited to an excess of £3,000 or £10,000 per case with the remainder born by the scheme. The provision is shown net of any reimbursement due from NHS Resolution.

"Other" provisions relates primarily to the clinicians pension tax scheme which will be funded through the DHSC.

Note 25.2 Clinical negligence liabilities

At 31 March 2021, £1,105k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Queen Victoria Hospital NHS Foundation Trust (31 March 2020: £1,243k).

Note 26 Contractual capital commitments

	2021	2020
	£000	£000
Property, plant and equipment	316	186
Intangible assets	-	46
Total	**316**	**232**

Note 27 Financial instruments

Accounting standards IAS 32, 39 and IFRS 7 require disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. See also policy note 1.13

All financial assets and liabilities are denominated in sterling. Carrying values are taken as a reasonable approximation of fair value

Note 27.1 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	3,359	**3,359**
Cash and cash equivalents	8,582	**8,582**
Total at 31 March 2021	**11,941**	**11,941**

Carrying values of financial assets as at 31 March 2020	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	8,006	**8,006**
Cash and cash equivalents	2,910	**2,910**
Total at 31 March 2020	**10,916**	**10,916**

Note 27.2 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	4,302	**4,302**
Obligations under finance leases	244	**244**
Trade and other payables excluding non financial liabilities	7,891	**7,891**
Total at 31 March 2021	**12,437**	**12,437**

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	11,520	**11,520**
Obligations under finance leases	324	**324**
Trade and other payables excluding non financial liabilities	10,679	**10,679**
Total at 31 March 2020	**22,523**	**22,523**

Note 27.3 Maturity of financial assets

All of the Trust's financial assets mature within 1 year.

Note 27.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the Statement of Financial Position which are discounted to present value.

	31 March 2021 £000	31 March 2020 restated* £000
In one year or less	8,867	18,063
In more than one year but not more than five years	3,898	4,871
In more than five years	-	-
Total	**12,765**	**22,934**

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

Note 28 Losses and special payments

	2020/21		2019/20	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Fruitless payments and constructive losses	1	7	1	4
Total losses	**1**	**7**	**1**	**4**
Special payments				
Ex-gratia payments	10	1	19	3
Total special payments	**10**	**1**	**19**	**3**
Total losses and special payments	**11**	**8**	**20**	**7**

Note 29 Events after the reporting date

No significant events have been identified.

Note 30 Related parties

No board members or members of the key management staff or parties related to them undertook any transactions with Queen Victoria Hospital NHS Foundation Trust during 2020/21, (2019/20 none).

The Department of Health and Social Care is the parent department, other public sector bodies included within the Whole of Government Accounts are also deemed to be related parties. The Trust has financial transactions with many such bodies.

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

The total income and expenditure transactions with the charity for the year are shown below.

	2020/21 Income	**Expenditure**	2019/20 Income	Expenditure
	£000	**£000**	£000	£000
The Queen Victoria Hospital NHS Trust Charitable Fund	**120**	**0**	149	0

Receivables and payables relating to the charity at 31 March 2021 were:

	31 March 2021 Receivable	**Payable**	31 March 2020 Receivable	Payable
	£000	**£000**	£000	£000
The Queen Victoria Hospital NHS Trust Charitable Fund	**208**	**0**	157	2

Whole of Government Accounts bodies with significant transactions (over £500k)

	2020/21		2019/20		2020/21		2019/20	
Income, Expenditure, Receivables and Payables	**Income**	**Expenditure**	**Income**	**Expenditure**	**Receivables**	**Payables**	**Receivables**	**Payables**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Brighton and Sussex University Hospital NHS Trust	**727**	**835**	654	895	**226**	**389**	935	632
Dartford and Gravesham NHS Trust	**-**	**446**	-	877	**-**	**229**	7	779
Medway NHS Foundation Trust	**72**	**801**	1	962	**72**	**716**	6	1,122
East Sussex Healthcare NHS Trust	**2**	**554**	-	700	**-**	**269**	-	705
NHS Resolution	**-**	**838**	-	788	**-**	**-**	-	-
Health Education England	**1,603**	**-**	1,551	-	**996**	**-**	630	-
NHS England	**28,982**	**-**	23,545	105	**510**	**-**	2,159	-
NHS Brighton & Hove CCG	**1,508**	**1**	1,219	-	**-**	**-**	11	-
HM Revenue and Customs (Employer NI and Apprenticeship levy)	**-**	**4,371**	-	4,118	**-**	**1,197**	-	1,113
NHS Pension Scheme (Employer contributions)	**-**	**6,897**	-	6,492	**-**	**688**	-	652
NHS South East London CCG (was Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark CCGs) *	**1,194**	**-**	954	-	**15**	**-**	-	-
NHS Surrey Heartlands CCG (was Guildford and Waverley, North West Surrey, Surrey Downs and East Surrey CCGS) *	**5,012**	**-**	4,684	-	**23**	**-**	279	-
NHS East Sussex CCG (was Hastings and Rother, High Weald Lewes Havens, Eastbourne Hailsham and Seaford CCGs) *	**10,307**	**850**	7,961	-	**52**	**843**	162	9
NHS Kent and Medway CCG (was Ashford, Canterbury and Coastal, Dartford Gravesham and Swanley, Medway, South Kent Coast, Swale, Thanet and West Kent CCGs) *	**14,138**	**4**	13,299	-	**49**	**-**	75	-
NHS West Sussex CCG (was Coastal West Sussex, Crawley and Horsham and Mid Sussex CCGs)*	**14,424**	**-**	11,433	-	**5**	**-**	572	-
	77,969	**15,597**	**65,301**	**14,937**	**1,948**	**4,331**	**4,836**	**5,012**

* Prior year comparatives consolidated for comparison for merged CCGs at 01/04/2020.

APPENDICES
6.1 Board of directors register

Name, title and appointment	Member attendance 2020/21						
	Board of directors	**Audit committee**	**Nomination and remuneration committee**	**Finance and performance committee**	**Quality and governance committee**	**Council of governors**	**QVH Charity**
Keith Altman Medical director 1 October 2019 to present	6 of 7 (member)	NA	NA	NA	6 of 7 (member)	NA	4 of 4 (member)
Paul Dillon-Robinson Non-executive director 1 October 2019 to 30 September 2022	7 of 7 (member)	5 of 5 (member)	4 of 5 (member)	11 of 11 (chair)	NA	NA	NA
Kevin Gould Non-executive director 1 September 2020 to 30 August 2023	7 of 7 (member)	5 of 5 (chair)	5 of 5 (member)	11 of 11 (member)	NA	NA	NA
Beryl Hobson Trust Chair Reappointed 1 April 2018 to 31 March 2021	7 of 7 (chair)	NA	4 of 5 (chair)	9 of 11 (member)	NA	3 of 3 (chair)	4 of 4 (member)
Steve Jenkin Chief executive 14 November 2016 to present	7 of 7 (member)	NA	NA	11 of 11 (member)	6 of 7 (member)	NA	NA
Abigail Jago + Director of operations 8 May 2018 to present	7 of 7 (member)	NA	NA	*6 of 11 (member)	4 of 7 (member)	NA	NA
Gary Needle Non-executive director 1 July 2020 to 30 June 2023, and senior independent director since 1 October 2019	6 of 7 (member)	NA	5 of 5 (member)	NA	7 of 7 (member)	NA	4 of 4 (chair)

Michelle Miles Director of finance and performance 1 February 2018 to present	7 of 7 (member)	NA	NA	11 of 11 (member)	6 of 7 (member)	NA	4 of 4 (member)
Karen Norman Non-executive director 8 April 2019 to 7 April 2022	7 of 7 (member)	5 of 5 (member)	5 of 5 (member)	NA	7 of 7 (chair)	NA	NA
Geraldine Opreshko + Director of workforce and organisational development 26 July 2017 to present	5 of 7 (member)	NA	NA	*7 of 11 (member)	6 of 7 (member)	NA	NA
Clare Pirie + Director of communications and corporate affairs 1 May 2017 to present	7 of 7 (member)	NA	NA	NA	NA	NA	NA
Nicky Reeves Interim director of nursing and quality 12 November 2020 to present	2 of 2 (member)	NA	NA	NA	2 of 2 (member)	NA	NA
Jo Thomas Director of nursing and quality 1 February 2015 to 11 November 2020	5 of 5 (member)	NA	NA	NA	5 of 5 (member)	NA	NA

* Finance and performance committee: AJ and GO available for a further 2 of the 11 meetings scheduled, but attendance was restricted by committee chair due to COVID.

+ denotes non-voting executive member of the board

6.2 Council of governors register 2020/21

Name	Constituency	Status of current term	Start of term	End of term	Meeting attendance
Barham, Chris	Public	Elected 1st term	01/02/2021	30/06/2023	0 of 0
Beesley, Brian	Public	Elected 1st term	01/07/2018	30/06/2021	1 of 3
Belsey, John	Public	Elected 2nd term	01/07/2017	30/06/2020	0 of 0
Bennett, Liz	Stakeholder[1]	Appointed	01/05/2017	30/04/2021	1 of 3
Bowden, Elizabeth	Public	Elected 1st term	01/02/2021	30/06/2023	0 of 0
Brown, Andrew	Public	Elected 1st term	01/02/2021	30/06/2023	0 of 0
Brown, St John	Stakeholder[2]	Appointed	01/04/2020	31/03/2023	2 of 3
Butler, Tim	Public	Elected 1st term	01/02/2021	30/06/2023	0 of 0
Farley, Miriam	Public	Elected 1st term	01/02/2021	30/06/2023	0 of 0
Fulford-Smith, Antony	Public	Re-elected 2nd term	01/07/2017	30/06/2020	3 of 3
Glynn, Angela	Public	Re-elected 2nd term	01/07/2017	30/06/2020	0 of 0
Haite, Janet	Public	Re-elected 2nd term	01/07/2017	30/06/2020	3 of 3
Halloway, Chris	Public	Re-elected 2nd term	01/07/2018	30/06/2021	3 of 3
Harley, Oliver	Public	Elected 1st term	01/02/2021	30/06/2023	0 of 0
Harold, John	Public	Elected 1st term	01/07/2019	30/06/2022	3 of 3
Holden, Julie	Stakeholder[3]	Appointed	06/01/2020	05/01/2023	2 of 3
Hunt, Douglas	Public	Elected 1st term	01/07/2017	30/06/2020	3 of 3
Lane, Andrew	Public	Elected 1st term	01/07/2018	30/06/2021	2 of 3
Lehan, Carol	Staff	Elected 1st term	01/07/2017	30/06/2020	2 of 3
Lockyer, Sandra	Staff	Elected 1st term	01/07/2017	30/06/2020	2 of 3
McGarry, Joe	Public	Elected 1st term	01/07/2017	30/06/2020	0 of 0
Martin, Tony	Public	Re-elected 2nd term	01/07/2017	30/06/2020	0 of 0
Migo, Caroline	Public	Elected 1st term	01/02/2021	30/06/2023	0 of 0
Roche, Glynn	Public	Re-elected 2nd term	01/07/2017	30/06/2020	0 of 0
Shore, Peter[4]	Public	Re-elected 2nd term	01/07/2019	30/06/2022	3 of 3
Smith, Roger	Public	Elected 1st term	01/02/2021	30/06/2023	0 of 0
Sim, Ken	Public	Elected 1st term	01/02/2021	30/06/2023	0 of 0
Stewart, Alison	Public	Elected 1st term	01/02/2021	30/06/2023	0 of 0
Tamplin, Robert	Public	Elected 1stterm	01/07/2017	30/06/2020	0 of 3
Tappenden, Tony	Public	Elected 1st term	01/07/2017	30/06/2020	0 of 0
Ward Booth, Peter	Public	Elected 1st term	01/02/2021	30/06/2023	0 of 0
Wiggins, John	Public	Elected 1st term	01/07/2017	30/06/2020	0 of 0
Williams, Martin	Public	Elected 1st term	01/07/2018	30/06/2021	3 of 3
Wilson, Mickola	Public	Elected 1st term	01/07/2017	30/06/2020	0 of 0
Yoganathan, Thavamalar	Public	Elected 1st term	01/07/2017	30/06/2020	0 of 0

[1] Representing West Sussex County Council
[2] Representing QVH League of Friends
[3] Representing East Grinstead Town Council
[4] Nominated Lead Governor since August 2019

6.3 Directors' biographies 2020/21

Keith Altman, Medical Director
Keith graduated in both dentistry and medicine from King's College Hospital, University of London and holds an award in medical leadership and diploma of legal medicine. He undertook his specialty training at Queen Mary's Hospital, Roehampton and The Royal Surrey County Hospital, Guildford. Keith was appointed as consultant maxillofacial surgeon at Brighton and Sussex University Hospitals NHS Trust in 1997 and was deputy medical director and lead for revalidation and appraisal 2013-17. He was appointed at QVH in 2017 and became medical director in October 2019.

Paul Dillon-Robinson, Non-Executive Director
Paul joined the board in October 2019. Paul, from Buxted near Uckfield, is a chartered accountant who spent 17 years working in the NHS as a head of internal audit for a range of organisations in the Kent, Sussex and Surrey area. He then spent nine years as director of internal audit for the House of Commons. Paul currently combines tutoring, training and consultancy work with non-executive and charity roles. At QVH, Paul chairs the finance and performance committee and is a member of the audit committee.

Kevin Gould, Non-Executive Director
Kevin joined the board in September 2017. He is a chartered accountant with more than 25 years' experience in the financial services and consulting industries, focussing on governance, risk and audit. Kevin has lived in Sharpthone (a village in Mid Sussex) since 1998, where he is a parish councillor. He is involved in a number of commercial and charitable organisations as a consultant and non-executive director. At QVH, Kevin chairs the audit committee and is a member of the finance and performance committee.

Beryl Hobson, Chair
Beryl joined QVH in July 2014 as a non-executive director and chair designate, before becoming chair in April 2015. She is the executive director of a governance consultancy and was previously chair of the NCT (National Childbirth Trust). Beryl was the first chair of Sussex Downs and Weald Primary Care Trust and has more than 20 years of board level experience gained in private, charity and NHS organisations. On 1 April 2018, Beryl was reappointed for a second term.

Steve Jenkin, Chief Executive
Steve Jenkin joined the Trust in November 2016. He was previously the chief executive of Peninsula Community Health, providing services across Cornwall and the Isles of Scilly including running 14 community hospitals. Prior to that Steve was director of health and social care with national charity Sue Ryder and chief executive of Elizabeth FitzRoy Support, a national charity supporting people with learning disabilities. Steve has an MBA through the Open University.

Abigail Jago, Director of Operations (non-voting)
Abigail Jago joined the Trust in May 2018 from Barts Health NHS Trust and has a wealth of experience in a range of senior operational, programme and strategic hospital roles. Since joining the NHS in 2000, she has managed services across multiple sites and has led change programmes in both an acute setting and across health and social care systems. Abigail is passionate about the NHS and the delivery of system wide improvement.

Michelle Miles, Director of Finance and Performance
Michelle was appointed in February 2018 from Croydon Health Services NHS Trust where she was deputy director of finance. Michelle has worked in the NHS for 20 years, having begun her career as a band 3 management accountant. She has a strong community background, having previously worked in community and primary care trusts. In 2009, Michelle moved to South London to take up her first role in an acute trust, an area of the NHS where she has remained. Michelle is particularly interested in understanding how finance professionals can support the delivery of excellent patient care and outcomes and all staff can help reduce wastage and improve efficiency.

Gary Needle, Non-Executive Director and Senior Independent Director
Gary Needle joined the board in July 2017. He has over 35 years' experience in health care executive management including posts as a chief executive in Brighton and Hove and as a director at the national quality inspectorate. He spent seven years in Qatar, where he was director of planning for the national health care system. Gary is chair of the board of trustees at East Grinstead Sports Club. At QVH, Gary chairs the charity committee and sits on the quality and governance committee. He was appointed to the role of senior independent director in October 2019.

Karen Norman, Non-Executive Director
Karen joined the board in April 2019 and lives in Brighton. She chairs the quality and governance committee and is a member of the audit committee. Karen has worked in healthcare for 40 years in both the public and private sectors in the UK, Australia, New Zealand and Gibraltar. She has 20 years' experience as an executive director at board level, as Gibraltar's chief nursing officer, and was director of nursing and clinical governance at Brighton and Sussex University Hospitals NHS Trust from 1993 to 2004. Karen has also worked as a management consultant for Crosby Associates, an American quality management company, and as an independent consultant, mostly in Scandinavia. She currently works as visiting professor, faculty member and research supervisor on the Doctorate in Management Programme at the University of Hertfordshire, and also as visiting professor at Kingston University and St George's, University of London, in the School of Nursing.

Geraldine Opreshko, Director of Workforce and Organisational Development (non-voting)
Geraldine has worked across health and social care since 1994 and holds an MSc in people and organisational development. She has held board level positions in the NHS since 2004 covering workforce, organisational development and transformation. Geraldine has worked across the east and south east of England including Bedfordshire, Norfolk, Cambridge and Kent in acute and community settings before joining QVH in May 2016.

Clare Pirie, Director of Communications and Corporate Affairs (non-voting)
Clare joined QVH in 2016. She has been supporting clear communication in the NHS since 2000, working at King's College Hospital and Brighton and Sussex University Hospitals, as well as for national and local NHS commissioning organisations. Clare's role at QVH includes corporate governance and development of the QVH Charity, as well as strategic leadership for communications and engagement.

Nicky Reeves, Interim Director of Nursing and Quality
Nicky Reeves was appointed interim director of nursing and quality in November 2020, having previously been the deputy director of nursing at QVH for five years. She trained at the Hammersmith Hospital and has 36 years of nursing experience. Nicky has held a range of posts at QVH and other trusts across Surrey and Kent,

leading and managing services at senior management level as well as having extensive operational nursing experience. Sher has always had a specialist interest in surgical nursing and started her QVH career 15 years ago as the Burns Centre Manager. Nicky is passionate about ensuring the patients who use our services get great care. Living locally, Nicky is well aware of the importance of QVH to the population of East Grinstead.

Jo Thomas, Director of Nursing and Quality
Jo was appointed in June 2015 having previously held the post in an interim capacity since February 2015. Before joining QVH, Jo held chief nurse positions in both commissioning and acute provider organisations. Jo began her NHS career as a nursing auxiliary before commencing her training in Brighton. Jo retired from the NHS in November 2020.

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

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

Our world-leading surgeons perform routine reconstructive surgery for the people of East Grinstead and surrounding areas, specifically for hands, eyes, skin and teeth, and are supported by therapy teams who are highly trained in the management of complex and high-risk trauma, disease and disfigurement.

The hospital also provides a minor injuries unit, expert rehabilitation services and a sleep service.

Everything we do is informed by our passion for providing the highest quality care, the best clinical outcomes and a safe and positive patient experience. You can find out more at qvh.nhs.uk

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

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