Queen Victoria Hospital NHS
NHS Foundation Trust

# ANNUAL REPORT, SUMMARY QUALITY ACCOUNTS AND SUMMARY FINANCIAL STATEMENTS

2009/10

QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST

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PRESENTED TO PARLIAMENT
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# CONTENTS

# 1.0 INTRODUCTIONS

# 1.1 CHAIRMAN'S INTRODUCTION

## WE ARE PLEASED TO PRESENT THE ANNUAL REPORT FOR QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST.

This year, our expert and committed staff have continued to deliver care of the highest quality, achieving excellent clinical standards and patient safety.

In a challenging financial climate, we have undertaken a number of key service reviews, and have introduced a programme of cost control measures. These have successfully controlled the annual increase in our costs and enabled us to continue to invest in our aged estate. We completed the plans for the development of our buildings and the first phase of a long term strategic plan for the site. Unfortunately the changing national financial position has meant that we are unable to progress these developments as quickly as we would like but we continue to drive forward improvements wherever possible.

This year has also seen some changes in the membership of the Board. I would like to thank those colleagues who have moved on for their invaluable contribution to our success this year. I look forward to working with my excellent team of executive and non-executive colleagues as we continue to build upon this year's strong performance.

**Peter Griffiths**
Chairman





# 1.2 CHIEF EXECUTIVE'S INTRODUCTION

## THROUGHOUT THE YEAR, WE HAVE MAINTAINED OUR FOCUS ON PROVIDING A HIGH QUALITY BURNS CARE AND RECONSTRUCTIVE SURGERY SERVICE TO THE POPULATION OF SURREY, SUSSEX, AND KENT, AND COMMUNITY HOSPITAL CARE TO THE PEOPLE OF EAST GRINSTEAD.

We are proud that QVH continues to be one of the leading hospitals in the country in terms of quality of care, staff satisfaction and financial performance.

We have continued to perform well in patient surveys for both outpatient and inpatient care, achieving scores that put us in the top 20% of hospitals in the country. We have undertaken a comprehensive review of patients' and visitors' opinions of our services, and instigated a number of changes to ensure that we continuously improve our standards.

We have maintained our strong record for patient safety and infection control, with only one case of hospital acquired MRSA and one case of Clostridium Difficile during the year. We received a clean bill of health following an inspection by the Care Quality Commission and are leading the way with innovative approaches to infection control at the cutting edge of reconstructive surgery.

This year we have identified that, despite high patient satisfaction and excellent performance against national targets, there are a number of ways in which we can improve the efficiency of our processes and make our services even more convenient for patients, minimising cancellations, late bookings, or requirements for several visits to the hospital for tests and scans. We have initiated a programme of streamlining to address these areas and will be realising the benefits over the coming year. The first phase of our restructuring programme is now being consulted upon and will enable us to reduce our overhead costs. This reflects the challenges we face in the coming year but I remain confident the Trust can take the required actions to maintain the quality of our services to patients whilst ensuring a sound financial position.

**Dr Adrian Bull**
Chief Executive

# 1.3 BOARD OF GOVERNORS' INTRODUCTION

## THE GOVERNORS OF QVH ARE IN A UNIQUE POSITION. WE ARE ABLE TO BRING AN ALL-ROUND PERSPECTIVE TO THE TRUST.

Many of us have direct experience of QVH because we or one of our family members received care as a QVH patient. We also have a detailed knowledge of the strategic direction and challenges through our work as a Board of Governors, our individual roles on other boards and committees and the open access we have to the Trust's executive and non executive directors. We have a thorough understanding of how things work on the ground in the hospital through our Governor tours which cover all aspects of the hospital's work from inpatients to outpatients, cleaning and infection control to estates and facilities, where we hear the views of both patients and staff.

From this position of understanding and experience, the Governors of QVH fully endorse the remarks made by the Chairman and Chief Executive. Together they have accurately described both the strong performance of QVH and its staff over the last year, and the challenges we face at this difficult time for the NHS. They have underlined the commitment of all at QVH to remain focused on quality, safety and clinical excellence.

The Governors of QVH oversee the activities of the hospital on behalf of the members and we do this against six themes;

- the experiences of patients as they follow their individual pathway
- the quality of the clinical service provided and its outcomes
- the levels of organisational performance achieved in relation to national standards and local plans
- the financial background
- the development plans both long and short term
- the maintenance of the ethos and reputation that underpins everything.

The Governors of QVH recognise that to continue achieving the highest levels of quality we must maintain a secure financial position and continue to innovate, making the most of opportunities to embrace new clinical practice and organisational procedures as medical science evolves.

**Bernard Atkinson**
Vice-Chairman of the Board of Govenors

# 2.0 DIRECTOR'S REPORT

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## WHO WE ARE AND WHAT WE DO

QVH became a foundation trust (FT) in July 2004 under the Health and Social Care (Community Health and Standards) Act 2003. As an FT we now have almost 11,000 public members across the South East of England.

The hospital is at the forefront of specialist care in reconstructive surgery. It is a regional and national centre for maxillofacial, reconstructive plastic and corneo plastic surgery, as well as for the treatment of burns. As a regional centre we serve a population of over four million people in the South East as well as those from further afield. We also provide community, medical and rehabilitation services to the local population.

## PRINCIPAL ACTIVITIES OF THE TRUST

In 2009/10, the principal activities of the trust were the provision of;

- reconstructive surgery (head and neck, maxillofacial, corneoplastic, oculoplastic, general plastic, oncoplastic, trauma rehabilitation therapy)
- burns care
- community medical services (in patient medical care, outreach therapy services and minor injuries unit).

The reconstructive surgery services are also provided in facilities at other hospital sites across Kent Surrey and Sussex – in particular at Surrey and Sussex Hospital, Brighton and Sussex University Hospitals, Medway Hospitals, Darent Valley Hospitals, Maidstone, and East Sussex Hospitals.

## BUSINESS REVIEW, MANAGEMENT COMMENTARY, OPERATING AND FINANCIAL REVIEW

QVH met its activity targets for the 2009/10. Changes to tariff, variation in case mix, reduction in one-off earnings (such as for out-of-network burns cases), and in-year cost pressures, have meant that QVH has not met all its financial targets, but has nevertheless maintained its Financial Risk Rating with Monitor at level 4. This is the second highest rating (out of five), which will be graded as 'excellent' by the CQC for management of resources, and means that there are no regulatory concerns. For the purposes of calculating the Trust's Financial Risk Rating, Monitor has excluded from the surplus calculation £2m of asset impairments relating to revaluation of the site at the year-end and investment in development, design, and planning for the strategic redevelopment of the site carried out over the past two years.

As the tertiary centre of expertise of reconstructive surgery for the South East region, QVH has continued to extend its contact and working relations with hospitals across the region, and its membership of and contribution to cancer networks in Sussex, Kent and Medway, and Surrey.

The principal risks and uncertainties facing the organisation arise from the national financial position, and are shared with the NHS in general. Specifically these are the freezing of the Payment by Results tariff for hospital services in 2010/11, and the continued increase in pay and non-pay costs through the implementation of national pay deals and general inflation. Current negotiations with NHS West Sussex are in hand to finalise contracts for 2010/11. Particular issues of concern relate to the need for continued financial support for the additional costs of providing reconstructive surgery for children, and microvascular surgical reconstruction of breasts at the same time as or following mastectomy, the costs of which are not adequately covered in national tariffs. Negotiations with the Burns Consortium have been completed satisfactorily. Increased controls on activity by PCTs (e.g. diversion of patients requiring hand surgery to the independent sector Sussex Orthopaedic Treatment Centre, reductions in tariff for urgent cases in excess of the 08/09 baseline levels, and other revenue pressures) require careful management and reduction of structural costs in the organisation.

In recent years considerable analysis of our estate has shown key vulnerabilities and inefficiencies arising from the current state and arrangement of our buildings. Significant investment has been made to stabilise the infrastructure (water, power, medical gases, etc.) Alternative plans have been drawn up to address the key requirement, which is the refurbishment or replacement of our theatres. These plans will be pursued in due course subject to affordability.

The further development of service line management and accounting at the start of the year highlighted the individual performance of our clinical areas. As a result detailed reviews have been conducted of Jubilee Centre (community) and of orthodontics, with plans now in train to improve the financial position of these services.





## ENVIRONMENT MATTERS

QVH is committed to minimising its impact on the environment.

A major part of our 2009/10 capital programme focussed on replacing heating systems within theatres and associated departments. The original system was over 40 years old and highly inefficient in its consumption of energy. Work on this was completed at the end of Q3 and early indications show that the new system has reduced gas consumption by 20%-25%.

We have seen a reduction in our water consumption of 10% during the last financial year due to a greater vigilance in responding to leaks across the ageing estate.

QVH is committed to developing its recycling programme. During 2009/10 we recycled 60% of all cardboard and 100% of waste electrical and electronic equipment (WEEE), together with 100% of confidential paper. We only managed to recycle 25% of aluminium and non-confidential paper, however plans are now in place to ensure this will be increased significantly in 2010/11.

We continue to support the prepayment of public transport costs such as rail season tickets. In addition, we have reviewed our staff travel programme and a revised car parking policy has placed a greater emphasis on discouraging staff from travelling to work by car. This policy will be implemented during the summer of 2010/11 and should result in a further 10% of staff seeking alternative ways in which to get to and from work.

QVH continues to support staff working from home as part of their normal working week and this financial year has seen the Remote Access System extended to cover 100 staff.

## EMPLOYEES

At any one time during 2009/10 the Trust employed approximately 900 individuals in approximately 800 'whole time equivalent' posts and had a low staff turn-over rate. The Trust is committed to providing a good working environment for its staff and has always enjoyed good results in the annual NHS staff surveys, achieving high scores for the last four years. For 2009/10 we have, again, achieved above average scores, including a high number which place us in the top 20% of Trusts. From last year's results we identified four issues that we wanted to improve upon in 2009/10 and our results show significant progress against three of these issues (reduction in staff working extra hours, improvements in staff receiving appraisals and having personal development plans). It is especially important to recognise that 2009/10 has been a challenging year for QVH. To achieve good staff survey results this year demonstrates the commitment and resilience of our staff.

## SOCIAL AND COMMUNITY MATTERS

The Trust has an established Public Engagement Committee which met six times during the financial year. Members of the committee include representatives of the West Sussex Local Involvement Network (LINks), Health Overview and Scrutiny Committee (HOSC), the Council for Voluntary Services and local government as well as lay representatives and public governors. During the course of the year the Committee has discussed a range of important issues and received a series of important presentation on topics including patient experience, quality and diversity, standards for better health and the 2009 national outpatient survey.

Despite its role as a regional centre of tertiary surgery, QVH has always had a close relationship with the local community in East Grinstead. Approximately 50% of the foundation trust's 10,650 public members live in East Grinstead and the surrounding villages so our programme of member communications and events reaches many people in our community. In 2009/10 approximately 450 local people attended a range of events including public meetings of the Board of Governors, the Annual General Meeting, an information evening on skin cancer and a departmental open evening in maxillofacial surgery.

During the course of the year, senior representatives of the Trust have attended local residents meetings to continue to discuss the plans for our site and estate, and we have continued to host regular meetings of the local NHS retirement fellowship. The Trust is a corporate member of the East Grinstead Business Association, and local businesses kindly support various initiatives and events, including the 2009 QVH staff awards. The Trust's charitable fund received generous donations and legacies throughout the year which have been used to support a wide variety of initiatives to improve patient experience, benefit staff facilities and improve the hospital site. The Trust also benefitted from the strong and generous support of its League of Friends.

Finally, the Trust enjoys a good working relationship with local media who are very supportive of the hospital. The Trust has been able to collaborate on the most effective methods and timings to employ to release important messages or respond to emerging news.

## ANALYSIS USING FINANCIAL KEY PERFORMANCE INDICATORS

A summary of the Trust's financial performance for the year ended 31 March 2010 is set out in the table below.

| | Plan YTD | Actual YTD |
|---|---|---|
| Turnover | £54.6m | £54.5m |
| EBITDA (earnings before interest, taxes, depreciation, and amoritization) | £4.3m | £3.7m |
| Surplus / (deficit) before impairments | £1.1m | £1.0m |
| Site redevelopment impairment | - | £(1.1m) |
| Asset value impairments | - | £(0.9m) |
| Surplus / (deficit) | £1.1m | £(1.0m) |
| Cash balance | £1.0m | £4.8m |
| Financial risk rating | 4 | 4 |
| Private patient Income (%) | 0.20% | 0.18% |

The year-end financial position of the Trust shows a £1.0m surplus before accounting for asset value impairments of £0.9m and impairment of capitalised development costs of £1.1m. Monitor's rating of our financial risk (the FRR) does not include the one off impairments, which means that their rating of the Trust is an FRR of 4 – which is classed as excellent by the Care Quality Commission.

This performance has been achieved through a focus on cost management measures through the year, improved efficiency and productivity across the hospital, and a tight focus on cash particularly in the second half.

Short term cost and cash management must be translated into sustainable cost and productivity improvements to maintain the Trust's performance in future years. The Trust has undertaken a strategic review of its operations and identified potential opportunities for reducing its cost base. Actions taken in 2009/10 successfully delivered a £700,000 improvement to the year end result compared to the mid year forecast. The Trust has begun implementation of the next phase in a number of areas such as reducing corporate and support costs, where a consultation on restructuring is now underway.





## PATIENT CARE

QVH continues to work to improve access to its specialist services for the population of the region. This includes the provision of clinics and day surgery at Medway, Dartford, Maidstone, Redhill, Brighton, and East Sussex Hospitals among others. The hospital is a centre of excellence and expertise in its core areas of burns and reconstructive surgery.

We continue to deliver against the Department of Health's national targets for waiting times. This year, we failed to achieve the threshold for one target – access within 31 days for patients referred with suspected cancer. However, this was due to over-stringent interpretation of rules on the implementation of this target on the part of the QVH which was subsequently recognised by the Department. Correct classification of all cases would have achieved the target and we are confident that all our patients benefitted from appropriate and timely treatment.

The hospital has an active and dynamic programme of clinical audit. We are now developing a standard approach to assessing the success rates of our 'free flap' transplant surgery – the fundamental and most complex element of our reconstructive surgery.

QVH also has a comprehensive and diligent approach to the identification and management of quality and risk through the Quality and Risk Committee. This key sub committee of the Board ensures that there is robust governance of all risk and quality issues through regular examination and review of the risk register, reported incidents, standardised quality metrics, and review of quality management programmes.

The results of the 2009 national NHS outpatients survey shows that QVH has maintained high levels of patient satisfaction. QVH ranks significantly better than most other Trusts surveyed across the country. Areas in which the hospital has improved since the last survey include staff knowing more about a patient's medical history, patients reporting greater privacy when being examined or treated, and shorter waiting times for appointments.

In 2009/10 we initiated a programme of streamlining to improve the efficiency of our processes and to make our services even more convenient for patients by minimising cancellations, eliminating late bookings, and reducing the need for several visits to the hospital for tests and scans. While many of the benefits of this work are expected to be realised in 2010/11, there have already been some significant improvements. For instance, we have reduced the average time from referral for plastic surgery outpatients appointments to booking an appointment from 40 days to just 5; there have also been significant improvements in our trauma pathways, and in the flexibility of our admissions procedures for patients undergoing elective surgery.

The Trust received 92 formal complaints during 2009/10 (5.2 complaints per 1,000 spells), an increase of 25 compared with 2008/09 (3.6 complaints per 1,000 spells). 85% of complaints received in 2009/10 were responded to within 25 working days in accordance with the NHS Complaints Procedure (April 2009). The remaining 15% of complaints took longer to investigate due to the complexity of the concerns raised or because the complaint related to care provided by QVH and other NHS organisations and, therefore, required a joint response. In all of these cases the patients were fully informed of any delays that were incurred. During the course of the financial year the Trust received 259 letters and cards of thanks and compliments to staff and departments.

## STAKEHOLDER RELATIONS

As a tertiary centre, QVH has key relationships with partner hospitals across the region, sharing facilities and offering its expertise to local populations. The provision of medical care in the community wards at East Grinstead is important for the local community, and much work has been done to ensure that this facility supports the local acute hospitals by providing step down and rehabilitation care for local patients.

NHS West Sussex is our lead PCT, and we continue to work closely together on the development and extension of our services, while also working constructively on issues such as procedures and treatments which are designated as not usually funded.

## DIRECTORS' DISCLOSURES

**Statement of Disclosure to Auditors**

For each individual who is a director at the time the annual report is approved so 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.

("Relevant audit information" means information needed by the NHS foundation trust's auditor in connection with preparing their report)

A director is regarded as having taken all the steps that they ought to have taken as a director in order to do the things mentioned above if he / she has:

- made such enquiries of his fellow directors and of the NHS foundation trust's auditors for that purpose and
- taken such other steps (if any) for that purpose as are required by his duty as a director of the NHS foundation trust to exercise reasonable care, skills and diligence.

## GOING CONCERN

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

The accounts have been prepared under a direction from Monitor.

Accounting policies for pensions and other retirement benefits are set out in note 8 to the accounts and details of senior employees' remuneration can be found on page 29 of the report.

# 3.0 PERFORMANCE

# 3.1 OPERATIONAL PERFORMANCE

OPERATIONAL PERFORMANCE AT QVH DURING 2009/10 WAS VERY GOOD. WE MET ALL OF OUR EXISTING COMMITMENT INDICATORS AND ALL BUT ONE OF THE NATIONAL PRIORITY INDICATORS.

This meets the criteria for a rating of 'excellent' by the Care Quality Commission in respect of quality of service, to match the 'excellent' for management of resources according to Monitor's assessment of our financial risk rating.

The national priority indicator that we did not meet was the target for 31 days from diagnosis to treatment for cancer. However, as explained in the director's report on page 15 this was due to our over-stringent interpretation of the implementation rules on the part of the QVH which was subsequently recognised by the Department of Health. Correct classification of these cases would have achieved the target.

While QVH met the 18 week referral to treatment target at Trust level, there were difficulties to achieve this in some specialties and work is in progress to ensure that all of our patients are treated within 18 weeks of being referred.

Infection rates were maintained at very low levels with only one case of Clostridium Difficile and one case of MRSA. Although we would like to see no cases of infection at all, this represents a very strong performance and reflects our excellent screening processes.

The table below shows the levels of activity across QVH in 2009/10 compared with those anticipated in the business plan.

In most areas of QVH's business we have had a very successful year, carrying out more activity than planned. The 9% difference between the planned and actual number of procedures carried out in outpatients is good news for patients who can receive their treatment sooner and more conveniently in an outpatient setting. For the NHS this is good news too as it means that, by avoiding the need to admit patients, we can carry out this type of treatment more cost effectively.

Activity levels across QVH

| | Plan | Actual | % difference |
|---|---|---|---|
| In-patient | 4,155 | 4,297 | 3% |
| Day cases | 8,504 | 8,095 | -5% |
| Emergencies | 4,012 | 3,955 | -1% |
| Outpatients new | 25,796 | 27,047 | 5% |
| Outpatients follow ups | 65,435 | 66,972 | 2% |
| Outpatient procedures | 10,090 | 10,956 | 9% |
| Attendances | 38,160 | 39,463 | 3% |
| Bed days | 19,808 | 20,031 | 1% |





# 3.2 SERVICE TRANSFORMATION

During 2009 QVH has been working on a 'streamlining' project to see how we can change the way we work to improve the care and service we provide to patients while using our own resources more efficiently.

A number of pilots have been carried out in different parts of the organisation (see case study below) which have shown that this approach has the potential to make significant improvements to the way we work and the service we offer patients.

We will now adopt this approach to improving our services across the hospital.

CASE STUDY

## NEW APPROACH SAVES TIME AND MONEY

By taking a fresh look at how it is working, QVH has managed to dramatically reduce the average time from referral to booking for plastic surgery outpatient appointments from 40 days to just five.

By reviewing data about how the hospital is performing, managers saw that this was an area where things could be better. The people who best know how to make improvement are usually the people doing the job on the front line. So everyone involved in plastic surgery outpatient appointments, from admissions officers to consultants, worked together to devise a new system.

They identified and introduced various changes. For example, bookings managers began proactively calling patients to make appointments, rather than waiting for patients to contact them, and introduced new working patterns so their office was open longer, making it easier for patients to get in touch.

By streamlining the process, they have improved the quality of service for patients and cut costs at the same time. Staff in other clinics and specialties will be using the same approach to take a fresh look at what improvements they could make over the coming months.

# 3.3 FINANCIAL PERFORMANCE

Following a challenging year, the financial position as at the end of March 2010 shows a surplus of £1m prior to a £2m expense for impairment of asset values. The plan for 2009/10 was a surplus of £1.1m.

In agreement with Monitor the Trust excluded the impairments for the purposes of calculating the Trust's Financial Risk Rating (FRR), and hence for the FRR the Trust shows a surplus for 2009/10 of £1m. The Trust's year end position maintains its FRR of 4.

## PERFORMANCE SUMMARY

The table below summarises the overall financial position for the Trust compared to 2008/09.

| | 2009/10 | 2008/09 |
|---|---|---|
| Turnover | £54.5m | £52.4m |
| Pay costs | £36.2m | £34.6m |
| Non pay costs excluding impairments | £16.4m | £16.0m |
| Interest and dividends | £0.9m | £0.6m |
| Surplus before impairments | £1.0m | £1.2m |
| Surplus / (deficit) | (£1.0m) | £0.8m |

Income increased by 3.7% overall last year which reflected both additional activity undertaken and changes to the national tariff. The Trust remained within its private patient income cap for the year with income of £95,000.

Pay costs increased by 4.6% over the year reflecting the national pay awards and a small increase in staff numbers employed. The Trust also incurred greater expenditure on interim and agency staff than in the previous year to support the increased activity levels.

The historically low level of interest rates nationally led to reduced income from interest received which generated only £14,000 in 2009/10 against £194,000 in 2008/09.

Measures were adopted throughout the year to control costs and drive through efficiencies focussing on headcount, non-pay expenditure, theatre productivity, off-site activity and Jubilee Ward. The measures undertaken have succeeded in taking the Trust's underlying position (excluding non recurrent items) from a monthly loss to a small surplus of £50-100K per month.

The cash position for the Trust at year end is £4.8m. It must be noted that £1.9m of this is a capital receipt received in this year for spend that is to be incurred in 2010/11, so the underlying position is actually £2.9m which is in line with previous years. This position has been recovered from a low point during the year of £1.8m by cost control and effective cash management.

It must be emphasised that, whilst some significant progress in strengthening the Trust's financial position has been made, there are significant challenges ahead with the economic pressures leading to less funding available in the future combined with higher demand and an estate that requires significant investment. The Trust has undertaken a strategic review of its operations which has been shared with Monitor and a plan for further improvement to the underlying financial position has been agreed. This will focus on reducing the cost base through streamlining service delivery and improved focus on the performance of individual specialties through service line reporting.





# 3.4 REGULATORY RATINGS

For both annual risk assessment and in-year monitoring, Monitor assigns a risk rating in three areas – finance, governance and mandatory services. Monitor uses these risk ratings to guide the intensity of its monitoring and signal to the Trust its degree of concern with any issues identified and evaluated.

Monitor uses four criteria to assess the Trust's financial risk rating: underlying financial performance; achievement of financial plan; financial efficiency; and liquidity. At the end of the financial year the Trust achieved a risk rating of four, in a range of one to five where five is best.

Monitor uses a traffic lights indicator for governance and mandatory services risk rating to indicate compliance with its terms of authorisation. An amber risk rating reflects that concerns exist about one or more aspects; a red risk rating indicates there are concerns that the Trust is in significant breach of its terms of authorisation.

At the end of the financial year QVH continued its excellent record from previous years by achieving green in all quarters (see tables below).

| | Annual Plan 2008/09 | Q1 2008/09 | Q2 2008/09 | Q3 2008/09 | Q4 2008/09 |
|---|---|---|---|---|---|
| Financial risk rating | 5 | 5 | 5 | 5 | 4 |
| Governance risk rating | ● | ● | ● | ● | ● |
| Mandatory services | ● | ● | ● | ● | ● |

| | Annual Plan 2009/10 | Q1 2009/10 | Q2 2009/10 | Q3 2009/10 | Q4 2009/10 |
|---|---|---|---|---|---|
| Financial risk rating | 4 | 4 | 4 | 3 | 4 |
| Governance risk rating | ● | ● | ● | ● | ● |
| Mandatory services | ● | ● | ● | ● | ● |

● **Red**
Rating indicates concerns that the trust is in significant breach of its terms of authorisation.

● **Amber**
Reflects that concerns exist about one or more aspects.

● **Green**
Excellent record.

# 3.5 STAFF ENGAGEMENT

## STAFF SURVEY

The 2009 staff survey was once again very positive for QVH with the Trust's scores for 18 of the 40 key indicators in the top 20% of results and a further 13 above average. There was a good response rate of 57% which was 5% higher than the previous year.

The table below sets out the following, comparing the Trusts scores with the national average:

- Four best scores
- Four worst scores
- Four areas of greatest improvement since 2008/09
- Four areas of greatest decline since 2008/09.

One key message from the 2009 survey is that, although we continue to perform better than the rest of the NHS in most areas, this year we have slipped in some scores against the QVH standard in 2008.

| | Best / worst scores | Change since 2008 | QVH score | National average |
|---|---|---|---|---|
| **Best scores** | | | | |
| Good communication between senior management and staff | ✓ | 2% worse | 48% | 32% |
| Perception of effective action from employer towards violence and harassment | ✓ | 0.02 worse | 3.82 | 3.62 |
| Staff intention to leave jobs* | ✓ | 0.13 worse | 2.30 | 2.51 |
| Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell | ✓ | New for 2009 | 15% | 23% |
| **Worst scores** | | | | |
| Percentage of staff suffering work-related injury in the last 12 months | X | 6% worse | 20% | 13% |
| Percentage of staff experiencing physical violence from patients/relatives in the last 12 months | X | 2% better | 4% | 4% |
| Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month | X | 3% worse | 34% | 34% |
| Percentage of staff appraised with staff development plans in the last 12 months* | X | 10% better | 64% | 65% |
| **Other significant changes since 2008/09** | | | | |
| Percentage of staff working extra hours | n/a | 7% better | 65% | 66% |
| Percentage of staff appraised in the last 12 months | n/a | 13% better | 75% | 75% |
| Percentage of staff suffering a work related injury in the last 12 months | n/a | 6% worse | 20% | 14% |
| Trust commitment to work/life balance (however this is still a best 20% score) | n/a | 0.11 worse | 3.66 | 3.51 |
| Quality of job design | n/a | 0.07 worse | 3.50 | 3.45 |

**This score is now only 1% below the NHS average and is a score that has significantly improved since the 2008 survey.*





## ONGOING ENGAGEMENT

As in previous years, we will use an action plan to address areas of weaknesses – three out of the four worst scores from last year's survey had significantly improved in the 2009 survey following the implementation of an action plan. For example, because appraisal completion scores in the 2008 staff survey were below average, we have worked on awareness raising of the requirement for appraisal, developed a monitoring system for recording completed appraisals and overhauled the appraisal documentation to make it more streamlined and user friendly.

In 2010/11 the Risk Team will be focussing on the work related injuries, physical violence and errors and near misses indicators, whilst the Head of HR will continue to lead the work to improve further on appraisal and personal development plans.

We will also be looking at other ways to measure staff satisfaction and engagement, including investigating the staff experience element of the toolkit that is being developed as part of the 'Energising Excellence' work led by the NHS South East Coast strategic health authority.

There are a number of communication forums within the Trust, including monthly team briefings, briefings and 'walkrounds' by the Chief Executive, the weekly 'Connect' newsletter and an intranet site.

The sixth annual QVH staff awards were held in November 2009. The awards, funded by the charitable fund and donations, honoured many staff for their achievements in services to patients, education, performance or loyalty to the organisation.

The Trust works in partnership with local trade union representatives to consult with staff and communicate changes, service developments, events, news and achievements. There are two official consultation forums: the Joint Consultative and Negotiating Committee (JCNC) which is made up of trade union and management representatives, and the Local Negotiating Committee which is made up of management and medical staff representatives and a British Medical Association representative.

Achievements this year include:

- During 2009/10, the Trust's Head of HR and Chair of the JCNC secured funding for a partnership working initiative. A 'partnership day' was held in February 2010 which included presentations and visits to wards and other departments within the Trust to raise awareness of partnership working and to encourage staff to get involved in trade union activities
- The Trust continues to run regular job evaluation panels to evaluate new and re-designed roles. This could not be managed without the dedicated support of the union representatives
- The Occupational Health Service that began in August 2008 is now well embedded in the Trust and is proving to be very successful. The Occupational Health Nurse runs health promotion events and awareness raising events throughout the year. The staff survey results continue to show that QVH has one of the lowest levels of stress across the acute specialist sector.

# 3.6 EQUALITY AND DIVERSITY

QVH is committed to ensuring that its services and employment practices are fair, accessible and appropriate for the diverse patient community we serve and the workforce we employ. Our patients, their carers and visitors and our staff deserve the very best we can give them in an environment in which all feel respected, valued and empowered.

Our approach to promoting equality and diversity (E&D) includes:

- The development and publication of an Equality Scheme 2010/13 and action plan to promote equality and diversity, to meet our legal duties, and to provide a framework for a co-ordinated approach on age, religion belief and sexual orientation
- Quarterly Equality, Diversity and Human Rights Steering Group
- An executive lead in E&D – the Director of Nursing and Quality
- Conducting and publishing the equality impact assessment of our services, functions and policies to ensure that equality and fairness are embedded into service delivery, planning, procurement and employment
- Providing equality, diversity and human rights training to all staff
- Annual workforce statistics are prepared for the board and published on the internet which include analysis of statutory E&D monitoring metrics
- Liaison with internal and external stakeholders in the development, implementation and review of equality action plans to continually improve our healthcare services. Stakeholders include PALS, patient information group, public engagement group and the patient experience taskforce
- Evaluation of employment and recruitment policies and practices is regularly conducted to ensure they are legally compliant and do not directly, indirectly, intentionally or unintentionally discriminate against applicants or employees
- Appraisal and personal development processes are in place to ensure consistent development opportunities for all staff.

## SUMMARY OF PERFORMANCE – WORKFORCE STATISTICS

The staff headcount has reduced from 962 in 2008/09 to 948 in March 2010.

The ethnicity of the South East Coast region, based upon census 2005 mid-year estimates is 91% White British. The ethnicity of staff at QVH is 82% White British and 15% Black and Minority Ethnic (BME). This indicates that QVH has an ethnically diverse workforce in comparison with the locality. Three percent of the workforce chose not to declare their ethnicity but 87% of the QVH foundation trust members chose not to declare.

One percent of staff have self declared that they have a disability, compared with 18% of the general population (2001 census). Eighty-one percent of staff chose not to formally declare their disability status however members have not, to date, been asked to declare their disability status.





The table below sets out the demographics of our staff and members

| | Staff 2008/09 | % | Staff 2009/10 | % | Membership 2008/09 | % | Membership 2009/10 | % |
|---|---|---|---|---|---|---|---|---|
| **Total** | 962 | | 948 | | 10,558 | | 10,649 | |
| **Age** | | | | | | | | |
| 0-16 | 0 | - | 0 | - | 0 | - | 0 | - |
| 17-21 | 16 | 2 | 12 | 2 | 40 | <1 | 35 | <1 |
| 22+ | 946 | 98 | 936 | 98 | 3,252 | 31 | 3,413 | 32 |
| Not stated | 0 | - | 0 | - | 7,266 | 69 | 7,201 | 68 |
| **Ethnicity** | | | | | | | | |
| White British | 807 | 84 | 767 | 82 | 1,179 | 11 | 1,270 | 12 |
| White Other | 9 | <1 | 30 | 3 | 6 | <1 | 8 | <1 |
| Asian or Asian British | 58 | 6 | 57 | 6 | 14 | <1 | 15 | <1 |
| Black or Black British | 13 | 1 | 19 | 2 | 10 | <1 | 11 | <1 |
| Other | 42 | 4 | 42 | 4 | 5 | <1 | 7 | <1 |
| Not stated | 33 | 3 | 33 | 3 | 9,344 | 89 | 9,251 | 87 |
| **Gender** | | | | | | | | |
| Male | 230 | 24 | 226 | 23 | 4,421 | 42 | 4,441 | 42 |
| Female | 732 | 76 | 722 | 77 | 5,192 | 49 | 5,212 | 49 |
| Trans-gender | 0 | - | 0 | - | 0 | - | 0 | - |
| Not stated | 0 | - | 0 | - | 945 | 9 | 996 | 9 |
| **Recorded disability** | | | | | | | | |
| No | 177 | 18 | 177 | 18 | 0 | - | 0 | - |
| Yes | 10 | 1 | 19 | 1 | 0 | - | 0 | - |
| Not stated | 775 | 81 | 761 | 81 | 10,558 | 100 | 10,649 | 100 |

# 4.0 RESOURCES

# 4.1 ESTATE AND CAPITAL

## DURING 2009/10 QVH COMPLETED A CAPITAL PROGRAMME ACROSS THE ESTATE. THIS PROGRAMME COMPRISED BOTH BACKLOG MAINTENANCE AND DEVELOPMENT PROJECTS AND ALL WERE COMPLETED WITHIN BUDGET.

We have carried out six maintenance projects this year with a total budget of nearly £1million. These have included replacement calorifiers (water heaters) and heating in the Staff Development Centre building. We have also upgraded our emergency lighting systems, improved critical ventilation systems and replaced a number of generators.

We have invested nearly £1.5million in development works, including developing a new paediatric assessment unit, works to improve privacy and dignity for patients on Burns and Canadian wings, and to improve the use of space across the site.

Over £1million is planned for continued investment in the coming year, including the refurbishment of Peanut Ward for children and improvements to electrical systems across the site.

# 4.2 SUSTAINABILITY

## COMMENTARY

In response to the carbon reduction strategy for the NHS, QVH is developing its own strategy to reduce its carbon footprint and is taking responsibility for its carbon emissions. This strategy will comprise four key actions:

- Establish Sustainable Development Management Plan for approval by the Board of Directors
- Sign up to the Good Corporate Citizenship Assessment Model
- Monitor, review and report on carbon
- Actively raise carbon awareness at every level of the organisation.

## SUMMARY OF PERFORMANCE – NON FINANCIAL AND FINANCIAL

The table below shows the improvements we are making in reducing waste, greater recycling and cutting our use of finite resources.

| Area | | Non financial data (applicable metric) 2008/09 | Non financial data (applicable metric) 2009/10 | Financial data (£k) 2008/09 | Financial data (£k) 2008/10 |
|---|---|---|---|---|---|
| | | Tonnes | Tonnes | | |
| Waste minimisation and management | Domestic | 59 | 60 | 10.5 | 12 |
| | Clinical | 109 | 120 | 52 | 59 |
| | Waste electrical equipement (WEE) | 1 | 1 | 1 | 1 |
| | Recycled | 10 | 12 | 2.5 | 3 |
| Finite resources | Water | 341,147m$^3$ | 299,920m$^3$ | 27 | 24 |
| | Electricity | 6,874 GJ | 9,926 GJ | 304 | 244 |
| | Gas | 21080 GJ | 21,500 GJ | 268 | 210 |
| | Gross internal area (GIA)m$^2$ | 19,290 | 20,290 | | |





## FUTURE PRIORITIES AND TARGETS

- Implementation of a carbon management strategy, approved by the Board of Directors
- Assurance that all new buildings will be low carbon by 2015
- Implementation of a sustainable travel plan for all NHS bodies, approved by the Board of Directors
- Creation and achievement of a target for better waste management
- Reduction in sources of carbon emissions by improvement of goods, services and equipment procurement
- Annual reporting on sustainability targets and performance results.

# 4.3 REMUNERATION REPORT

Salary entitlements of senior managers

| | 1 April 2009 to 31 March 2010 | | | 1 April 2008 to 31 March 2009 | | |
|---|---|---|---|---|---|---|
| Name and title | Salary (Bands of £5,000) £000 | Other remuneration (Bands of £5,000) £000 | Benefits in kind Rounded to nearest £100 | Salary (Bands of £5,000) £000 | Other remuneration (Bands of £5,000) £000 | Benefits in kind Rounded to nearest £100 |
| P. Griffiths (Chairman) | 40-45 | 0 | 0 | 40-45 | 0 | 0 |
| J. Beech (Non Executive Director) | 10-15 | 0 | 0 | 10-15 | 0 | 0 |
| R. Hoey (Non Executive Director) | 0 | 0 | 0 | 5-10 | 0 | 0 |
| R. Leech (Non Executive Director) | 10-15 | 0 | 0 | 10-15 | 0 | 0 |
| H. Ure (Senior Independent Director and Non Executive Director) | 15-20 | 0 | 0 | 15-20 | 0 | 0 |
| S. Winning (Non Executive Director) | 10-15 | 0 | 0 | 10-15 | 0 | 0 |
| A. Bull (Chief Executive) | 140-145 | 0 | 0 | 35-40 | 0 | 0 |
| C. Becher (Director of Nursing & Quality) | 15-20 | 0 | 0 | 90-95 | 0 | 0 |
| T. Bolot (Interim Director of Finance) | 115-120 | 0 | 0 | 0 | 0 | 0 |
| S. Colclough (Chief Executive) | 0 | 0 | 0 | 95-100 | 0 | 0 |
| S. Flint (Director of Finance) | 55-60 | 0 | 0 | 100-105 | 0 | 0 |
| K. Lavery (Medical Director) | 10-15 | 185-190 | 0 | 10-15 | 165-170 | 0 |
| A. Parker (Director of Nursing & Quality) | 60-65 | 20-25 | 0 | 0 | 0 | 0 |
| M. Sherry (Director of Performance, Technology & Innovation) | 65-70 | 0 | 0 | 0 | 0 | 0 |

Pension entitlements of senior managers

| | | Lump sum at age 60 related to real increase in pension | Total accrued pension at age 60 at 31 March 2010 | Lump sum at age 60 related to accrued pension at 31 March 2010 | Cash Equivalent Transfer Value at 31 March 2010 | Cash Equivalent Transfer Value at 31 March 2009 | Real increase in Cash Equivalent Transfer Value |
|---|---|---|---|---|---|---|---|
| | | | (Bands of £2,500) | (Bands of £5,000) | (Bands of £5,000) | | |
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| A. Bull (Chief Executive) | 7.5-10 | 22.5-25 | 20-25 | 60-65 | 424 | 238 | 174 |
| C. Becher (Director of Nursing & Quality) | 0-2.5 | 0-2.5 | 45-50 | 135-140 | 1,006 | 801 | 14 |
| S. Flint (Director of Finance) | 0-2.5 | 0-2.5 | 25-30 | 75-80 | 456 | 418 | 9 |
| K. Lavery (Medical Director) | 0-2.5 | 2.5-5 | 70-75 | 210-215 | 1,805 | 1,505 | 45 |
| A. Parker (Director of Nursing & Quality) | 5-7.5 | 15-17.5 | 20-25 | 65-70 | 407 | 239 | 104 |
| M. Sherry (Director of Performance, Technology & Innovation) | 0.2.5 | 2.5-5 | 20-25 | 70-75 | 523 | 442 | 39 |

## NOTES

1. As non executive directors do not receive pensionable remuneration, there are no entries in respect of pensions for non executive directors. This applies also to T. Bolot.

2. 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.

3. 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.

4. Real increase in CETV - This 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.

5. The following directors joined the board during the year: A. Parker (August 2009), M. Sherry (August 2009).

C.Becher left the board in May 2009.
S. Flint left the board on 16 October 2009.

The following directors left the board during 2008/09: S.Colclough (January 2009), R.Hoey (September 2008).

# 5.0 GOVERNANCE

# 5.1 BOARD OF DIRECTORS

## MEMBERSHIP

At 31 March 2010, the QVH Board of Directors consists of the Chairman, five non executive directors (of which one post is vacant) and four executive directors (of which one post was vacant but was filled on 1 April 2010 with the appointment of Richard Hathaway as the Director of Finance and Commerce).

The biographies and core skills of the current membership of the Board are as follows:

**Peter Griffiths**
**Chairman**

Peter Griffiths has spent his entire career in healthcare. His last executive appointments within the NHS were as Deputy Chief Executive for the Management Executive at the Department of Health, and Chief Executive of the Guys & Lewisham first-wave NHS Trust.

In the mid 1990s Peter moved to the King's Fund as Deputy Chief Executive and Director of their management college and subsequently headed up the Health Quality Service, an independent organisation providing quality development support to health services nationally and internationally. He was also President of the Institute of Health Services Management.

On appointment in 2005 he stepped down as Non Executive Director of the Sussex Downs and Weald Primary Care Trust, to become Chairman of Queen Victoria Hospital NHS Foundation Trust at East Grinstead.

Peter is a member and the Deputy Chairman of the Foundation Trust Network Board.

**Dr Adrian Bull**
**Chief Executive**

Adrian served for six years as a Medical Officer in the Royal Navy, completing his training in General Practice. On joining the NHS, he gained his MD in epidemiology and became a consultant in public health medicine, holding several senior medical and management positions in health authorities and NHS trusts.

In recent years Adrian has worked in the private sector as Group Medical Director of PPP Healthcare, Managing Director of Carillion Health, and Commercial and Medical Director for Humana Europe.

**Tim Bolot**
**Interim Director of Finance**

Tim joined the Trust for an interim period until a permanent replacement for the post was recruited to take up the post on 1 April 2010.

An experienced and well respected finance director, Tim is an expert in short term and interim engagements.

He is a trained barrister and solicitor as well as an accountant and has worked extensively within the NHS and also in the commercial sector.

**Mr Ken Lavery**
**Medical Director**

Mr Ken Lavery, Consultant in Oral and Maxillofacial Surgery, trained in Dentistry and Medicine at the University of Dundee. After qualifying he undertook post-graduate training in general surgery, plastic surgery, ENT and neurosurgery, prior to commencing his specialist training as an oral and maxillofacial surgeon at Queen Victoria Hospital and Guy's Hospital.

Ken's specialty areas are the surgical aspects of head and neck oncology, reconstruction and salivary gland surgery. He has represented his specialty both regionally and nationally.

**Amanda Parker**
**Director of Nursing & Quality**

Amanda previously held the post of Deputy Director of Nursing.

She trained at the Middlesex Hospital, going on to specialise in renal medicine before she joined QVH as a theatre nurse in 1992. Here she developed her career in perioperative care, which included a joint role with St Georges, London as a lecturer practitioner.

Amanda brings strong academic and operational experience to the role. She is a Registered Nurse Teacher with an MA in Nursing & Education, has an MSc in surgical and perioperative care and served as Chair of the Education Committee on the Board of the Association for Perioperative Practice (AfPP).





**Mary Sherry**
**Director of Performance, Technology & Innovation**

Mary joined the Trust from Portsmouth Hospital NHS Trust where she was Associate Director for Patient Pathways.

She has previously worked at Surrey & Sussex Healthcare NHS Trust as Acting Director of Operations and Access and Capacity Manager and managed a range of specialties at St George's and Kingston Hospitals.

Mary has a strong reputation for working very closely with clinicians and staff of all disciplines to achieve improvements in patient services and is well known for her partnership working.

Mary's focus is to formulate the transformation plan based on the systems thinking work that the Trust has been piloting recently. She is also working with the Board and the senior management team, as well as front line staff, to strengthen the Trust's performance and rationalise operating costs, ahead of future financial constraints on the NHS. Key to this is how IT can support both the transformation plan for the Trust and also day to day delivery of services.

**Hugh Ure**
**Senior Independent Director**
**Non Executive Director**

Hugh is from Haslemere in Surrey. He was appointed to the Board in December 2000 and was appointed Deputy Chairman and Senior Independent Director in April 2007.

He is a retired company director, who had an extensive international senior management career with Reckitt Benckiser, during which his postings included Australia, Papua New Guinea, South Africa, Sri Lanka, Ireland and the UK.

He also has wide ranging experience as a non executive director, including terms as Chairman of the Board of a private sector pension fund, a non executive director on a board in the Ministry of Defence, and is currently a non executive director of the Benenden Healthcare Society.

**Jeremy Beech**
**Non Executive Director**

Jeremy, from Frittenden in Kent, is a consulting engineer.

He has spent over 30 years in the fire service occupying positions as Assistant Chief Fire Officer in the London Fire Brigade and then Chief Fire Officer of Kent. He was also one of five UK members of the Channel Tunnel Safety Authority and UK Chairman of the Rescue and Public Safety Working Group.

Jeremy is also a non executive director of the Port of London Authority and a trustee of the Kent Foundation.

**Dr Renny Leach**
**Non Executive Director**

Renny lives in Forest Row and has held chief executive, managing director and chairman positions across an extensive range of high profile UK and Scandinavian academic and commercial life science organisations.

Renny's career has focused on the promotion and management of clinical research, particularly in the field of paediatrics and the new born baby. He was previously Director of Clinical Research at the Institute of Child Health and Great Ormond Street Hospital for Children NHS Trust and has worked for the UK Medical Research Council and the Horsham-based charity Action Medical Research.

More recently he has been working with a number of public and venture capital funded companies developing new clinical treatments for common conditions including cancer.

**Shena Winning**
**Non Executive Director**

Shena, from Elham near Canterbury, is a chartered accountant. Formerly Finance Director of CarpetRight plc, she has over 20 years experience within the retail sector.

Shena is a Non Executive Chairman of Swallowfield plc and was a Non Executive Director of South East Kent Community Health Trust from July 1996 to January 1998.

During the course of 2009/10 there have been vacancies at both executive and non executive director level; a new post of Executive Director of Performance, Innovation and Quality was created; and, thus, a fifth non executive director post was established to balance the Board.

The post of Executive Director of Finance was vacant on a substantive basis for 6 months but filled on an interim basis for all of that time. A permanent appointment to the post was made from 1 April 2010.

The Trust is working with the Appointments Commission to fill the vacant non executive director position.

Full details of the membership of the Board throughout the year are set out in the table on page 35.

## COMPLIANCE

The Trust is confident that the Board of Directors has complied with;

- the framework for the corporate governance of Foundation Trusts as set out in the Monitor Code of Governance (www.monitor-nhsft.gov.uk); and
- the terms of the QVH Constitution, Schedule 1 of the Trust's terms of authorisation as an NHS Foundation Trust (www.monitor-nhsft.gov.uk).

Furthermore, during the 3 and 4 quarters of 2009/10, the Board of Directors;

- undertook an internal review of its effectiveness and has agreed a series of adjustments to its practices to further strengthen its meetings programme; and
- reviewed its practice of holding meetings in private and, in consultation with the Board of Governors, agreed to continue to do so but also to review this decision on an annual basis.

## INTERESTS

A register of directors' interests is kept by the Trust and is available on request to the Head of Corporate Affairs (Company Secretary).

## MEETINGS

Board of Directors meetings were held in private and attended by the Governor Representative, Programme Director, Deputy Medical Director and Head of Corporate Affairs (Company Secretary).

There are three sub-committees of the Board:

- Audit Committee
- Quality and Risk Committee
- Nomination and Remuneration Committee.

The following table sets out the members of the Board throughout 2009/10 and their membership of, role in, and attendance of, each of the three sub-committees. The Audit Committee and Nomination and Remuneration Committee membership comprises solely of non executive directors. The Quality and Risk Committee contains both executive and non executive directors.





Board of Directors membership and attendance record

| Name, title and appointment | Meeting attendance and role 2009/10 | | | |
|---|---|---|---|---|
| | Board of Directors | Audit Committee | Nomination and Remuneration Committee | Quality and Risk Committee |
| **Peter Griffiths**<br>Chairman<br>1 April 2005 to 31 March 2012 | 12 of 12<br>Chairman | - | 3 of 3<br>Member | - |
| **Hugh Ure**<br>Senior Independent Director<br>1 October 2005 to 30 September 2011 | 10 of 12<br>Deputy Chairman | 6 of 6<br>Member | 3 of 3<br>Chairman | - |
| **Jeremy Beech**<br>Non Executive Director<br>1 October 2005 to 30 September 2012 | 12 of 12 | - | 3 of 3<br>Member | 4 of 4<br>Chairman |
| **Renny Leach**<br>Non Executive Director<br>1 January 2007 to 31 December 2010 | 10 of 12 | - | 2 of 3<br>Member | 3 of 4<br>Member |
| **Shena Winning**<br>Non Executive Director<br>1 October 2005 to 30 September 2012 | 12 of 12 | 6 of 6<br>Chair | 3 of 3<br>Member | - |
| **Adrian Bull**<br>Chief Executive<br>December 2008 to present | 12 of 12 | 2 of 6<br>In attendance | 3 of 3<br>Member | 4 of 4<br>Member |
| **Ken Lavery**<br>Medical Director<br>April 2008 to present | 8 of 12 | - | - | 2 of 4<br>Member |
| **Sally Flint**<br>Director of Finance<br>October 2002 to October 2009 | 5 of 12 | 3 of 6<br>In attendance | - | 2 of 4<br>Member |
| **Ed Rothery**<br>Acting Director of Finance<br>September 2009 to October 2009 | 2 of 12 | - | - | - |
| **Tim Bolot**<br>Interim Director of Finance<br>October 2009 to March 2010 | 6 of 12 | 2 of 6<br>In attendance | - | - |
| **Caroline Becher**<br>Director of Nursing<br>September 2003 to May 2009 | 1 of 21 | - | - | - |
| **Amanda Parker**<br>Acting Director of Nursing<br>May to July 2009<br>Director of Nursing & Quality<br>July 2009 to present | 1 of 12<br><br>9 of 12 | -<br><br>- | -<br><br>- | 1 of 4<br>Member<br>3 of 4<br>Member |
| **Mary Sherry**<br>Director of Performance, Innovation & Technology<br>August 2009 to present | 8 of 12 | - | - | - |

# 5.2 NOMINATION AND REMUNERATION COMMITTEE

The purpose of the Nomination and Remuneration Committee is to review and make recommendations to the Board of Directors on the composition, balance, skill mix and succession planning of the Board. It recommends the appointment of executive directors. It is responsible for setting the overall policy for the remuneration of all Trust staff, and it specifically authorises the remuneration packages for the Chief Executive, the executive directors and other very senior manager posts.

The Nomination and Remuneration Committee was formed on 1 April 2007, replacing the former Remuneration Committee. This is the third annual report of the committee.

## MEMBERSHIP OF THE COMMITTEE

Membership of the committee and their attendance record is set out in the Board of Directors table above.

## ACTIVITIES OF THE COMMITTEE

During 2009/10 the Trust continued with an agreed rolling work programme. Three new directors were appointed - Nursing & Quality, Performance, Technology & Innovation and Finance. A new Head of Corporate Affairs was also appointed. The committee made decisions or recommendations on the following issues:

- Standards of business conduct
- The 2009 national pay award
- Recruitment of, job description and salaries for new executive director posts
- Pay for executive directors and other very senior managers
- Revised terms of reference
- Revision to Aligned Appointments Principles
- Review of welfare and reward
- Vacant non executive director post
- Appointment of the Interim Director of Finance
- Review of appraisal and leadership
- Work plan for 2009/10.

The broad aim of the Trust's remuneration policy is to set remuneration levels in order to attract and retain skilled and talented staff throughout the Trust. In doing this, the committee takes account of current NHS practice, as well as considering wider commercial practice. The majority of staff in the Trust are covered by the national Agenda for Change terms and conditions. The Chief Executive, executive directors and other very senior managers are covered by local senior manager terms and conditions. Doctors in the trust are covered by the national medical and dental terms and conditions.

Pay and terms have been set based on external benchmarking, recommendations by the Head of HR and benchmarking both salary and terms and conditions against other NHS organisations using information networks, the very senior managers pay framework and reports on NHS and foundation trust boardroom pay. The Hay report commissioned in the 2008/09 financial year was used to benchmark salaries, and the Agenda for Change pay rise for 2009/10 was also taken into account.

In line with the requirements of the Code of Governance, the executive directors' performance was monitored and reviewed against Trust and individual objectives through the appraisal process, both informally and formally.

The contracts are permanent and substantive and all have a three month notice period with the exception of the Chief Executive, who has a six month notice period. There are no specific clauses regarding compensation and early termination.

The Board of Governors, on the recommendation of the Appointments Committee, determines the remuneration and appointment of the Trust's Chairman and the non executive directors. Ann Horscroft, a publicly elected governor, is Chairman of the Appointments Committee. Other members are drawn from public governors, stakeholder and staff governors.

The salary details of the Trust's Chairman, executive and non executive directors are set out in the financial statements. There have been no compensatory agreements in the 2009/10 financial year.

A list of executive directors who served in the 2009/10 financial year is included in the Board of Directors table above.





# 5.3 AUDIT COMMITTEE

One of the main principles of the NHS Foundation Trust Code of Governance is that the board should establish formal and transparent arrangements for considering how they should apply the financial reporting and internal control principles and for maintaining an appropriate relationship with the NHS foundation trust's auditors. In this respect the code provides that the board must establish an audit committee composed of non-executive directors which should include at least three independent non-executive directors. The board should satisfy itself that at least one member of the audit committee has recent and relevant financial experience.

In line with the code the Trust's Audit Committee is comprised of two non-executive directors. Shena Winning, one of the non-executive directors and chair of the committee is a chartered accountant with over 20 years experience within the retail sector.

The prime purpose of the Audit Committee is the scrutiny of the establishment and maintenance of an effective system of governance, risk management and internal control. This should include 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.

During 2009/10 the committee fulfilled its objectives, as set out in its terms of reference, by undertaking the following areas of work;

- monitoring the integrity of the Trust's financial statements
- reviewing the Trust's internal controls and the Trust's risk management systems
- providing the Board with assurance that the Trust has the appropriate risk management and assurance processes in place
- reviewing and monitoring the effectiveness of the Trust's internal audit function
- reviewing and monitoring the external auditors' independence and objectivity
- reviewing the adequacy of management responses to issues identified by audit activity
- receiving regular reports from the Trust's Local Counter Fraud Manager
- undertaking an annual review of the effectiveness of the Audit Committee itself.

In addition to the above, during the year the Audit-Committee commissioned specific pieces of work as set out below.

During the year the Trust evaluated and financially appraised the options for development of its ageing estate. The committee commissioned the Trust's external auditors to undertake a review of the options and their appraisals drawn up by the Trust. The auditor's report provided valuable independent comment that aided the Board in making informed decisions on the future of the Trust.

The committee also engaged the external auditors in preparation for discussions with Monitor in relation to the future of the Trust and consideration of the site development impairment. The auditors provided a letter outlining their opinion on the site development impairment which was provided to Monitor. In carrying out this work the external auditors took all necessary steps to ensure they maintained their independence from the Trust.

During the year the committee has commissioned the internal auditors to undertake specific pieces of targeted analysis to test the strength of controls or procedures. The outcomes from these have been used to review and re-emphasise procedures and controls across the Trust.

During the year the committee was also pleased to receive reports from the Trusts internal and external auditor's that provided the committee with a review of the trust's Internal controls and risk management systems. The internal auditors were able to report full or significant assurance for 85% of the areas reviewed, resulting in a Head of Internal Audit Opinion of significant assurance.

The Audit Committee meets four time's a year and is attended by the Trusts Director of Finance and has representation from the Trust in respect of risk management, the external and internal auditors, and local counter fraud service. At the beginning of every Audit Committee meeting there is a closed session between the Chair of the Audit Committee and committee members with the internal and external auditors.

Attendance of the meetings held during 2009/10 is shown in the table on page 35.

# 5.4 MEMBERSHIP

## SUMMARY

Membership numbers and profiles remained broadly stable compared with those in 2008/09 (and described in the QVH annual plan 2009/10).

Moderate recruitment targets for 2009/10 were set but not achieved: public membership fell by 2% and staff membership rose by 0.2%.

A demographic breakdown of the membership is included in the equality and diversity table on page 25.

| Constituency | Eligibility criteria (I) | Eligibility criteria (II) | Membership at 31 March 2010 |
|---|---|---|---|
| Public | Over 18 years of age | Resident in Kent, Surrey or Sussex | 10,559 |
| Staff | | Employed by QVH for over 12 months | 844 |
| | | | **11,403** |

## STRATEGY

The membership strategy for the year focused on 'meaningful' membership, which is interested in the future of the hospital and which widely represents the population the hospital serves. In 2009/10 governors were actively encouraged to recruit members by meeting with local interest groups and visiting public libraries, schools career evenings and supermarkets.

## DISCLOSURES AND CONTACT DETAILS

A public register of members is available for viewing by contacting the Head of Corporate Affairs. Members should also contact the Head of Corporate Affairs to communicate with governors and / or directors.





# 5.5 BOARD OF GOVERNORS

## THE BOARD OF GOVERNORS REPRESENTS, AND IS ELECTED BY, THE PUBLIC MEMBERS OF THE TRUST.

The Board of Governors has important powers, such as appointing or removing the Chairman of the Trust and other non executive directors. It also decides how much they will be paid and other conditions of service. The Board of Governors also approves the appointment of the Chief Executive and can appoint or remove the Trust's external auditor.

The Board of Governors works through a Governors Steering Group, which supports and facilitates the work of the Board of Governors and actively engages governors in adding value to the Trust. The Governor Steering Group now holds joint meetings with the non executive directors during the year.

Members can contact governors and directors via the Trust or the Trust website and members of the public can view the Register of Governors' interests by contacting the Head of Corporate Affairs.

## BOARD OF GOVERNORS PUBLIC MEETINGS

The Board of Governors holds five public meetings a year, including the AGM, in venues in and around East Grinstead. At the public meetings there is a standing item on the agenda regarding the membership, when feedback from the Trust, the governors or members can be discussed freely. At the AGM the Board of Governors is presented with the annual report and the annual accounts, plus the auditor's report.

The Directors, who are accountable to the governors, attend all public Board of Governors meetings and provide the Board of Governors with reports on the management of the Trust, infection control figures and any other matters the governors should be kept aware of. Full and frank discussions take place at public meetings to which the public are encouraged to attend and at which they have the opportunity to ask questions.

## GOVERNOR REPRESENTATIVE

The Board of Governors is represented by the Governor Representative, who attends all Board of Directors meetings in full (in a non-voting capacity) and provides a report to governors through formal meetings of the Governors Steering Group and Board of Governors and through the governors monthly 'Update'. The Governor Representative also acts as a link between the Board of Directors and the Board of Governors and actively projects, protects and enhances the Trust`s reputation. In 2009/10 this position was held by Bernard Atkinson.

## VICE CHAIRMAN OF THE BOARD OF GOVERNORS

At the beginning of September 2009 the first Vice Chairman of the Board of Governors was appointed - a significant step in the evolution of the Board of Governors. The Vice Chairman provides advice to individual governors as required, supports governors in progressing governor business, represents the governors externally as necessary, works with the Chairman of the Trust on developing Board of Governors' governance arrangements as well as advising him on governor matters. He chairs the Governors Steering Group and when the Chairman cannot attend or, if it is appropriate, he also chairs the Board of Governors.

## MEMBERSHIP OF THE BOARD OF GOVERNORS

Public governor elections took place in 2009 with 10,583 election forms being sent out and 2,374 forms being received; a turnout of 22.6%.

Part or full time staff who have a contract with the Trust and who have worked at the Trust for more than 12 months are eligible to be members and stand as staff governor.

Four meetings of the Board of Governors took place between 1 April 2009 and 31 March 2010. As in previous years, apart from sickness, attendance at meetings was good.

The table below lists the members of the Board of Governors, whether they are a public or staff member or representing a stakeholder, and the number of meetings they attended in 2009/10.

| Governor | Constituency | Term | Meetings attended (4) |
|---|---|---|---|
| Bernard Atkinson | Public | Re-elected 2008 to 2011 | 4 |
| Len Barlow | Public | Re-elected 2008 to 2011 | 4 |
| Stuart Barnett | Public | Re-elected 2008 to 2011 | 4 |
| Gillian Baxter | Public | Elected 2008 to 2011 | 4 |
| Edward Belsey | Public | Elected 2009 to 2012 | 3 |
| John Bowers | Public | Re-elected 2008 to 2011 | 4 |
| Gillian Brack | Public | Elected 2009 to 2012 | 3 |
| Tom Cochrane | Stakeholder: Guinea Pigs Club | Reappointed 2007; resigned December 2009* | 1 |
| Sarah Creamer | Stakeholder: NHS West Sussex | Appointed 2008 to 2011 | 0 |
| Mabel Cunningham | Staff | Elected 2008 to 2011 | 4 |
| Roy Daisley | Stakeholder: University of Brighton | Reappointed 2007 to 2010 | 3 |
| Peter Dingemans | Public | Re-elected 2008 to 2011 | 4 |
| Peter Evans | Stakeholder: Local Authority | Reappointed 2009 to 2012 | 2 |
| Adrian Fuchs | Public | Elected 2008 to 2011 | 4 |
| Mary Goode | Stakeholder: Brighton & Sussex University Hospitals NHS Trust | Appointed 2009; resigned January 2010** | 2 |
| Peter Harper | Public | Elected 2008 to 2011 | 4 |
| Bill Hatton | Public | Re-elected 2008 to 2011 | 4 |
| Caroline Hitchcock | Public | Re-elected 2008 to 2011 | 4 |
| Ann Horscroft | Public | Re-elected 2007 to 2010 | 2 |
| Sue Hull | Public | Elected 2008 to 2011 | 3 |
| Valerie King | Public | Re-elected 2008 to 2011 | 4 |
| Carol Lehan | Staff | Elected 2008 to 2011 | 3 |
| Shirley Mitchell | Public | Re-elected 2008 to 2011 | 3 |
| Martin Plimmer | Public | Re-elected 2008 to 2011 | 4 |
| Derek Pocock | Stakeholder: League of Friends | Reappointed 2006 to 2009 | 4 |
| Andrew Robertson | Public | Elected 2009 to 2012 | 4 |
| Chris Rolley | Stakeholder: East Grinstead Town Council | Reappointed 2007 to 2010 | 2 |
| Manya Sheldon | Public | Elected 2009 to 2012 | 4 |
| Ian Stewart | Public | Elected 2008 to 2011 | 4 |
| Alan Thomas | Public | Elected 2009 to 2012 | 2 |
| Alison Tweddle | Public | Re-elected 2007 to 2010 | 4 |
| Jill Walker | Public | Elected 2008 to 2011 | 3 |
| Sharon Watkinson | Public | Re-elected 2007 to 2010 | 3 |
| Vacant position*** | Staff | Vacant | n/a |

**Sponsorship withdrawn* ***Awaiting another representative* ****Staff member stood, but ineligible nomination*





# 5.6 DISCLOSURES

Communication and information giving actions are described in the staff engagement section of this report. In addition, formal consultation is described in the Trusts Change Management Policy which was reviewed in 2009/10.

The Trust has a Whistle Blowing Policy which explains to staff how they can raise concerns about issues in the Trust. It includes the role of the NHS Counter Fraud Service. This is also covered as part of the Trust's induction programme. In addition, the Trust has the Datix incident reporting system which allows staff to raise concerns and record incidents relating to clinical issues.

A formal staff consultation exercise began in March 2010 which relates to a review of the orthodontic service.

The Trust reports sickness absence data quarterly via the Health and Safety Committee and monthly at the People, Quality and Capital meeting. From March 2010 it is also reported on a monthly basis to the Board (prior to this it was bi-annual). The Trust has had a steady average of 3.5% sickness absence over the last four years, which is 1% below the NHS average and 10% below the acute sector average in 2008/09. Seasonal variations are noted (i.e. higher in winter, lower in summer).

# 6.0 SUMMARY QUALITY ACCOUNTS

# 6.1 SUMMARY OF THE QUALITY ACCOUNTS 2009/10

At QVH we believe that, to be of the highest quality, a service must be:

- expert
- holistic
- safe
- comfortable
- reliable
- accessible.

Because of the high-risk and complicated nature of the surgery we carry out, safety is a key issue at all levels of the organisation. We undertake a thorough and comprehensive audit of our observations, response times, preventive precautions and levels of expertise to ensure the highest standards. We also have a rigorous programme of incident reporting, investigation, and follow up to ensure that lessons are learned and improvements made at every opportunity.

We are continuing to develop our objective metrics of quality, safety and patient experience. We are currently focusing on the development of standard metrics for the outcomes of our core surgical competencies in burns treatment, and microvascular surgery on free flaps. Each clinical directorate is developing its measure of the quality of the care they provide. The information on outcomes published in our quality accounts demonstrate a performance that is consistently higher (with better outcomes and lower complication rates) than published or national standards. As a leading centre for the services we offer, we will continue to develop and set the standard for outcome measures.

Patient dignity, comfort, and satisfaction are equally important to the hospital which provides local medical services as well as tertiary surgery. In the past year we have carried out a comprehensive analysis of patients' views on the non-technical aspects of their care and have responded to their key concerns. We are proud to have one of the best records in the country from the annual patient survey, and aim to provide personal care at every level.

As part of our focus on the patient experience, we are concerned to ensure that our achievement of access targets is not at the expense of other aspects of patient satisfaction – in particular cancellations of appointments or operations, and late bookings. We have adopted regular measures of these aspects of care and our quality accounts contain a clear commitment to avoid cancellations and late bookings.

The following sections outline some of the highlights from our full quality accounts which are available from the trust website and on request.





# 6.2 PATIENT SAFETY

**Culture of safety and reporting**
At QVH we have a strong culture of patient safety and reporting. Organisations that report more incidents usually have a better and more effective safety culture because an organisation cannot learn and improve if it is unaware of any problems. We have continued to encourage clinical incident reporting, in which staff not only report all safety incidents affecting staff and patients, but also all 'near miss' events, and we have seen an 8% increase in incident reporting, against a 3% increase in activity. However, we are continuing to work towards further improvements.

One example of how incident reporting can affect patient care is the trust's efforts to reduce patient falls on the Jubilee rehabilitation unit. The nature of the patients cared for on Jubilee, where mobilisation plays a large part in their rehabilitation, means some patient falls are inevitable. However, through new methods of risk assessment, with targeted care for at risk patients, we have reduced the number of falls by 25% in 2009 compared with 2008.

A staff survey of perceptions of the culture of patient safety at QVH was carried out in 2009, with many encouraging results. It also highlighted some areas for improvement, particularly with regard to patient safety leadership from medical staff and staff handovers, which we will be focusing on.

**After Action Review**
We have introduced a new method of learning from clinical incidents called the After Action Review. It is a method of formal debriefing, led by a trained facilitator. Staff involved in a clinical incident are brought together in a no-blame environment to discuss what should have happened, what actually happened, why there was a difference, and what can be learnt for next time.

**Patient safety walk-rounds**
We have introduced executive patient safety walk-rounds to further allow staff to communicate their concerns about patient safety, from 'ward to board'. Executives and patient safety managers visit a different area of the hospital every month and hold an open, no-blame discussion, allowing all staff to voice any concerns about patient safety. Issues raised have ranged from estate issues - such as lighting around outside paths used by patients - to medication errors, patient confidentiality and consent.

**Patient observations**
We have made it a priority to improve the completeness and quality of our physiological observations (pulse, blood pressure, respiratory rate, temperature, pain scores and sedation level) as this is an important way of spotting the early signs of deterioration in a patient's condition. We have made good progress on this over the last year.

When observations fall outside set limits an appropriate response should be triggered. However, only approximately 20% of 'triggers' are being acted upon in line with protocols. This is partly due to the current system we have been using which places very tight limits on physiological variation before demanding escalating care. Nursing staff are tending to ignore breaches as they know the patient is safe.

We are therefore developing a new 'Early Warning Score' physiological observation chart to enable correct identification of patients at risk of deterioration. This is currently being successfully trialled in the burns unit, and will be rolled out to the main hospital in April 2010.

**Theatre checklist and briefings**
Since November 2009, QVH has implemented a system of pre-theatre list team safety briefs, where the whole theatre team joins together at the start of the day to discuss safety issues, list order, equipment and imaging needs, antibiotic prophylaxis and staffing for the day. This has rapidly become part of normal practice, and we have seen a reduction in clinical incidents reported that relate to poor communication in the theatre complex since their introduction.

Implementation of the World Health Organisation theatre checklist for all surgical procedures, with a 'time out' before incision to cross check the details of the patient, was also formalised ahead of schedule in November 2009. From a previously poor use of the checklist in June 2009, we are now approaching compliance of over 80%.

**'Matching Michigan'**
Ninety seven per cent of acute trusts in England are participating in 'Matching Michigan', a quality improvement project for intensive treatment units (ITUs) based on a model developed in the United States which reduced central venous catheter bloodstream infections (CVC-BSIs).

QVH started collecting Matching Michigan data in December 2009. Monthly data is submitted on the number of patients with CVCs, number of CVCs and number of CVC-BSIs.

QVH ITU has had a zero incidence of CVC-BSIs. We remain fully committed to ensuring that patient care relating to CVCs is fully compliant with the Matching Michigan interventions.

**Ventilator care bundle**
We provide a bundle of care to prevent patients on ventilators from acquiring ventilator acquired pneumonia (VAP). Our rate of VAP is difficult to establish, as many of our long term ventilated patients are admitted with inhalational burn injuries which predispose to pneumonia. However, the care bundle, which includes gut protection to avoid gastric ulceration and micro-aspiration, patient positioning and breaks in sedation regimes, has been fully implemented, with a compliance of 100%.

**Consultant review of emergency admissions**
We have made some progress against our priority of ensuring that the care plans for all emergency admissions made by medical and nursing staff are reviewed by a consultant within 24 hours, with a 20% improvement in compliance over the last year. However, this will remain a priority for the forthcoming year, and continued improvements in the way junior doctors document consultant reviews are being made as reviews are not always documented if no changes are required.

**Hand hygiene**
Adherence to our hand hygiene policy has been a key focus during 2009/10 and we have achieved an improvement in our hand hygiene compliance across the organisation from 73% in early 2009 to 87% in 2010. We will continue to focus on compliance during 2010/11 as our aim is to achieve a compliance score above 90% for hand washing against all five 'moments' of hand hygiene audited.

# 6.3 CLINICAL QUALITY AND EFFECTIVENESS

**Skin and head and neck cancer surgery**
As a major centre for skin cancer and cancer of the head and neck, we have sought to develop specific outcome indicators for these services.

At the QVH Melanoma and Skin Cancer Unit (MASCU), extensive audit in 2009 has developed four key measures of clinical quality and effectiveness which can now be monitored through use of the new MASCU database. These are melanoma excision rates, incomplete excision rates in basal skin carcinoma, complications in axillary and inguinal lymph node block dissections and patient satisfaction.

QVH rates for incomplete excision in basal skin carcinoma and complications in axillary and inguinal lymph node block dissections are consistent or better than national published rates. Melanoma excision rates are significantly better than those suggested by NICE. In terms of patient satisfaction, 96% of patients rated their treatment as excellent or very good.

Markers of clinical quality for head and neck cancer surgery will potentially include 'free flap' (microvascular surgery) survival rates, length of stay, surgical complication rates, waiting time from surgery to radiotherapy and two- and five- year survival rates.

Collection of data for these has proved challenging as we provide surgical care to patients from three different cancer networks (Maidstone, Brighton and Guildford) which all use different data collection systems. However, we have now implemented the Liverpool head and neck cancer database and intend to improve reporting on these outcome measures for 2010/11. This database will also enable us to improve our contribution to the DAHNO (data for head and neck oncology) national head and neck cancer database.

**Microvascular surgery**
Microvascular surgery (free tissue transfer or 'free flap' surgery) is central to QVH's reconstructive work. We have established a continuous, prospective database of all patients undergoing microvascular breast reconstruction which has been populated with two years of retrospective data, enabling us to benchmark ourselves against other units willing to share results. A recent audit of 45 plastic surgery units found that only four other centres use a prospective database in this way to record their outcome data. QVH free flap survival rates are 98.7% compared with national and international published rates of between 95% and 98%.

It is hoped to extend use of this database to other 'free flaps' when fully operational for breast patients.

**Burns care**
While there continues to be discussion by the national burn care group about defining appropriate outcome measures for burns, we looked to our patients to help define quality measures and it became clear that getting our patients healed as quickly as possible, and out of hospital in a safe and timely manner, had the biggest impact on patient wellbeing.

We are developing a length of stay indicator. Research suggests that on average one day of inpatient stay is required for every one percent of body area that is burnt or scalded in children or young adults while it is one to two days per percent of body area burned for the elderly or medically unfit. In 2010/11 we will see how our rates compare to this standard.

We believe that with excellent, timely treatment an uncomplicated burn should be healed within approximately 21 days. We believe we are one of the only units in the country to have an ongoing measure of burn wound healing. This has already led to a significant improvement in healing times with earlier operations, reduced infection rates and ultimately reduced costs. We can use this approach for assessing new innovations as we have now built a bank of historical data.





**Orthognathic surgery and orthodontics**
Data is now being collected in orthognathic surgery which will enable us to report on patient satisfaction, inferior dental alveolar nerve injury rates and stability data – whether the new position of the facial bones is retained. An audit of QVH nerve injury rates shows them to be below, or at the lower end, of those in published literature.

The PAR (peer assessment rating) index is the generally accepted tool for measuring quality in orthodontics. Scores over 70% represent a very high standard of treatment and QVH scores for 2009/10 showed a mean improvement score of 94.75%.

**Hand surgery**
A monthly audit takes place with all therapists and hand consultants and complications are collated both in the therapy department and through a trauma database. Each complication is investigated to ensure that there is no disturbing trend. In 2009, the QVH rupture rate following repair of flexor tendon injuries was 6-7% compared with a national average of 9-13% and the successful resolution of pain following trapeziectomy was 92% compared with a national average of 85-88%.

**Corneoplastic surgery**
The quality of outcome for QVH cataract patients is in line with national outcomes with uncomplicated cataracts. Our outcome figures exceed national outcomes in patients who have other eye diseases in addition to the cataract being treated.

**Anaesthetics**
Few benchmarks and markers of quality in anaesthetics are available. Attempts to link quality of anaesthesia to surgical outcome have proven difficult and the emphasis has turned to outcome figures based on incidents, events and complications during the perioperative period and patient reported scores on quality of recovery.

We have developed our own anaesthetic reporting system in line with the speciality based incident reporting system developed by the Royal College of Anaesthetists and the NPSA. We have now collected three months' worth of figures and hope to provide a simple metric indicator of performance in the near future.

**Mortality reviews and end of life care**
All deaths within 30 days of surgery are discussed at bi-monthly joint hospital clinical audit meetings. In the past 12 months we have reviewed 11 surgical deaths at QVH, 8 of which have been related to burn injuries, and a further 19 deaths that occurred away from QVH within 30 days of surgery. Our rates of non-burns related surgical deaths remain low and stable, but are continuously monitored.

Non-surgical deaths in our rehabilitation service are formally reviewed at quarterly meetings attended by the clinical director of community medicine and GP representatives, together with senior nursing staff and the clinical director of audit and outcomes. In the past 12 months, 14 deaths on Jubilee ward have been discussed, almost 60% of which were related to terminal cancer.

Lessons learned from mortality reviews are disseminated to the clinical policy committee and through the directorate structure.

Identifying patients admitted for end of life care has been made a priority and the use of the Liverpool Care Pathway, a protocol for patient care in the final hours and days of life, has been encouraged for all such cases. Recent audit showed that it was correctly implemented in 80% of cases.

**Clinical audit and research**
At QVH, clinical audit is seen as a routine element of clinical practice and all staff undertaking clinical outcomes and audit activity have the appropriate time, knowledge and skills available to them. There is a wealth of clinical audit and outcomes work currently underway at QVH, and well-attended joint hospital clinical audit meetings are held every two months to ensure that lessons learned from this programme of work are shared across the organisation.

This increasing level of QVH participation in clinical research demonstrates our commitment to improving the quality of care we offer and making our contribution to wider health improvement. During 2009/10 QVH was involved in conducting 22 clinical research studies.

# 6.4 PATIENT EXPERIENCE AND ACCESS

**Patient reported outcome measures (PROMs)**
PROMs enable the effectiveness of procedures delivered to patients to be measured by comparing patients' self-reported health status before and after.

We are taking part in the national PROM projects for varicose vein and groin hernia surgery. Although QVH performs low numbers of these procedures and they are performed by visiting surgeons, the participation rates compared to the national average nonetheless reflect the commitment of our staff to supporting the audit and focusing on patient outcomes. So far we have collected information on participation rates and patients' pre-operative condition, and we are now awaiting the national audit results.

In addition, QVH trialled the use of a cataract surgery PROM and the results so far have been in line with the published figures on which it is based.

We are now developing PROMs in breast, hand and orthognathic surgery.

**QVH outliers service**
We have developed an award-winning 'outliers' service for lower limb trauma patients referred from surrounding hospitals.

Previously, patients were automatically brought to acute care and often spent long periods on wards waiting to be transferred to surgery or discharged home. Now, a community-based outreach practitioner, supported by a dedicated team of consultant surgeon, consultant anaesthetist and administrator support, visits patients in their own home. Patients appreciate the point of contact and the personal care and have the option of using long-term dressings rather than surgery. Where surgery is necessary, post-surgical wound care can be provided in the community, saving on long journeys for follow up.

For patients referred from the community or other acute trusts we have seen a 35% reduction in the average time from referral to admission and a 23% reduction in length of stay at QVH before discharge. This approach has also proved cost effective, reducing inpatient stay for pre-tibial lacerations to 3.5 days.

**Privacy and dignity**
Maintaining privacy and dignity for our patients is a priority for us. We have participated in three reviews with our commissioners and peer-review trust to provide an assurance that we are addressing adequately the privacy and dignity of our patients.

During 2009/10 we have built additional single rooms and provided ensuite facilities and additional screening. As a result, in the last three months, no patient has needed to share accommodation with patients of the opposite sex, except for within our intensive care and high dependency facility.

The national inpatient survey results for QVH show that when asked 'did you feel you were treated with dignity and respect while in hospital?' our scores have remained consistently high at 95% and 96% in 2007 and 2008 respectively.

To ensure we continue to listen to patients views on our ability to provide privacy and dignity in their care, our newly revised discharge questionnaire asks specific questions about this.





**Patient experience action plan**
In 2009/10 we developed our first patient experience action plan to tackle the key issues that patients tell us affect their experience of our hospital. All sources of patient feedback were collated, including PALS enquiries, formal complaints, national inpatient and outpatient survey results, internal survey results, comments left online at www.nhs.uk and feedback from our volunteers and public governors.

These were reviewed by a patient experience taskforce - a working group comprising staff, governors and patients – who identified themes and prioritised actions. The action plan is being implemented following approval by the trust board in February 2010.

Alongside the development of the action plan, we have been making changes that had already been identified as necessary to improve patient experience including new wheelchairs for use at our main entrance and by our porters, making toiletries available to buy in our restaurant, since we no longer have an on-site shop and reviewing the tests performed on patients waiting for eye clinic appointments, reducing waiting times.

**Patient information**
The results of our inpatient survey showed that while, overall, patients were very happy with the information provided by QVH, there could be improvements in the written information given to them about their condition or treatment. The patient information group has reviewed the information currently being given to patients to ensure it is relevant, accessible and timely and we have made several changes as a result.

A re-usable, wipe-clean bedside guide has been developed for inpatients. A comprehensive signage review, looking at all signage from the patient's perspective has also been undertaken and the findings submitted to the estates department to feed into the 2010/11 business plan.

**Streamlining services**
In 2009/10 we initiated a programme of streamlining to improve the efficiency of our processes and make our services even more convenient for patients by minimising cancellations, late bookings and the need for several visits to the hospital for tests and scans. While many of the benefits of this work are expected to be realised in 2010/11, there have already been some significant improvements. For instance, we have reduced the average time from referral for plastic surgery outpatients appointments to booking an appointment from 40 days to just five.

**Encouraging feedback**
To support our patient experience action plan, we are changing the way that we encourage feedback and improving the opportunities for patients and visitors to leave feedback in real-time. During 2010/11 we will ensure that ward exit surveys are available in all wards so patients can tell us about their experience while staying with us and increase the number of comment boxes and comment cards available across the site. We will also improve the way that we analyse feedback, collating and analysing at regular and frequent intervals to provide real-time analysis of our patients' experiences, and we will improve the way we communicate the changes we make in response to feedback.

# 7.0 SUMMARY FINANCIAL STATEMENTS

# 7.1 SUMMARY FINANCIAL STATEMENTS

The following statements are a summary of the information contained in the full accounts.

Copies of the full accounts are available from the Finance Department, The Queen Victoria Hospital NHS Trust, Holtye Road, East Grinstead, West Sussex, RH19 3DZ.

## GOING CONCERN

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

## STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2010

| | 2009/10 | 2008/09 |
|---|---|---|
| | £000 | £000 |
| **Operating income** | **54,536** | 52,419 |
| **Operating expenses excluding impairments** | **(52,622)** | (50,603) |
| **Impairments of property, plant and equipment** | **(1,999)** | (366) |
| **Operating (deficit) / surplus** | **(85)** | 1,450 |
| **Net finance costs** | **(959)** | (642) |
| **(DEFICIT) / SURPLUS FOR THE YEAR** | **(1,044)** | 808 |
| | | |
| **Other comprehensive income:** | | |
| Revaluation losses on property, plant and equipment | **(1,388)** | (532) |
| Increase in the donated asset reserve due to receipt of donated assets | **13** | 194 |
| Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets | **(257)** | (283) |
| **TOTAL COMPREHENSIVE (EXPENSE)/INCOME FOR THE YEAR** | **(2,676)** | 187 |





## STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2010

| | 31 March 2010 | 31 March 2009 | 1 April 2008 |
|---|---|---|---|
| | £000 | £000 | £000 |
| Non-current assets | **32,263** | 33,811 | 31,170 |
| Current assets | **8,459** | 7,806 | 9,414 |
| Current liabilities | **(7,616)** | (5,840) | (4,988) |
| Non-current provisions | **(522)** | (517) | (523) |
| **TOTAL ASSETS EMPLOYED** | **32,584** | 35,260 | 35,073 |
| | | | |
| **TAX PAYERS' EQUITY:** | | | |
| Public dividend capital | **12,212** | 12,212 | 12,212 |
| Revaluation reserve | **14,075** | 15,769 | 17,450 |
| Donated asset reserve | **2,326** | 2,692 | 2,185 |
| Income and expenditure reserve | **3,971** | 4,587 | 3,226 |
| **TOTAL TAX PAYERS' EQUITY** | **32,584** | 35,260 | 35,073 |

Signed on behalf of the Board:

**Dr Adrian Bull**
Chief Executive

12 July 2010

## STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

| | Total | Public dividend capital | Revaluation reserve | Donated assets reserve | Income and expenditure reserve |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| Taxpayers' equity at 1 April 2009 | **35,260** | 12,212 | 15,769 | 2,692 | 4,587 |
| Total comprehensive income for the year | **(1,044)** | 0 | 0 | 0 | (1,044) |
| Revaluation losses and impairment losses property, plant and equipment | **(1,388)** | 0 | (1,266) | (122) | 0 |
| Increase in the donated asset reserve due to receipt of donated assets | **13** | 0 | 0 | 13 | 0 |
| Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets | **(257)** | 0 | 0 | (257) | 0 |
| Transfers to the Income and Expenditure reserve in respect of disposed assets | **0** | 0 | 0 | 0 | 0 |
| Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure reserve | **0** | 0 | (428) | 0 | 428 |
| Taxpayers' equity at 31 March 2010 | **32,584** | 12,212 | 14,075 | 2,326 | 3,971 |
| Taxpayers' equity at 1 April 2008 | **35,073** | 12,212 | 17,450 | 2,185 | 3,226 |
| Total comprehensive income for the year | **808** | 0 | 0 | 0 | 808 |
| Revaluation losses and impairment losses property, plant and equipment | **(532)** | 0 | (1,128) | 596 | 0 |
| Increase in the donated asset reserve due to receipt of donated assets | **194** | 0 | 0 | 194 | 0 |
| Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets | **(283)** | 0 | 0 | (283) | 0 |
| Transfers to the Income and Expenditure reserve in respect of disposed assets | **0** | 0 | (125) | 0 | 125 |
| Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure reserve | **0** | 0 | (428) | 0 | 428 |
| Taxpayers' equity at 31 March 2009 | **35,260** | 12,212 | 15,769 | 2,692 | 4,587 |





## STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2010

| | 2009/10 £000 | 2008/09 £000 |
|---|---|---|
| **Cash flows from operating activities** | | |
| Net cash inflow from operations | **6,368** | 3,599 |
| **Cash flows from investing activities** | | |
| Interest received | **14** | 194 |
| Payments to acquire property, plant and equipment | **(3,607)** | (5,353) |
| Payments to acquire intangible assets | **(47)** | (16) |
| PDC dividends paid | **(1,037)** | (824) |
| **Increase/(decrease) in cash** | **1,691** | (2,400) |
| **Cash and cash equivalents at 1 April 2009** | **3,110** | 5,510 |
| **Cash and cash equivalents at 31 March 2010** | **4,801** | 3,110 |

## PRUDENTIAL BORROWING CODE

For 2009/10 the Trust was granted a Prudential Borrowing Limit of £11.5m (2008/09 £11.2m) and continued to have a £3m working capital facility as in 2008/09. During the year the Trust did not make any borrowings.

## PRIVATE PATIENT CAP

The Trust has a private patient cap which relates to 0.2% of total patient related income. Private patient income during the year was within the cap.

## BETTER PAYMENT PRACTICE CODE

The Better Payment Practice Code requires the Trust to aim to pay all valid non-NHS invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. Due to tighter cash flow management during the year performance fell below target.

| | 2009/10 | | 2008/09 | |
|---|---|---|---|---|
| | Number | £000 | Number | £000 |
| Total Non-NHS trade invoices paid in the year | 13,597 | 12,711 | 15,219 | 17,947 |
| Total Non-NHS trade invoices paid within target | 7,823 | 7,903 | 14,215 | 15,359 |
| **Percentage of Non-NHS trade invoices paid within target** | **58%** | **62%** | 93% | 86% |
| Total NHS trade invoices paid in the year | 1,131 | 7,379 | 958 | 5,385 |
| Total NHS trade invoices paid within target | 117 | 585 | 331 | 2,032 |
| **Percentage of NHS trade invoices paid within target** | **10%** | **8%** | 35% | 38% |

## AUDIT FEES

Audit fees for the year to 31 March 2010 were £88,000, including VAT (£88,000 in 2008/09).

The auditors also carried out additional work on behalf of the Trust. They audited the restatement of the 2008/09 accounts and Statement of Financial Position as at 1 April 2008 under international accounting standards, the fee for which was £43,000 including VAT. They also carried out a "due diligence" review of the Trust's plans to develop the site, for a fee of £31,000 including VAT. In undertaking this work the Audit Committee ensured that the auditor's objectivity and independence was safeguarded.

## OTHER AREAS TO NOTE

The accounting treatment of pensions and other retirement benefits is set out in note 8 to the full accounts and the details of senior employees' remuneration can be found above, in the Remuneration Report.

The Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

Impairments of property, plant and equipment resulted from:

1. Impairment due to a project being discontinued due to current funding issues (£1,092,000).

2. The revaluation of the hospital buildings (£907,000).

## 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 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 accounting officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed Queen Victoria Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Queen Victoria Hospital NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS foundation trust Financial Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, 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 Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and

- prepare the financial statements on a going concern basis.

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

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

**Dr Adrian Bull**
Chief Executive

7 July 2010





## INDEPENDENT AUDITORS' STATEMENT TO THE BOARD OF GOVERNORS OF QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST

We have examined the summary financial statement for the year ended 31 March 2010 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity, the related notes and the information in the Directors' Remuneration Report that is described as having been audited.

## RESPECTIVE RESPONSIBILITIES OF DIRECTORS AND AUDITORS

The directors are responsible for preparing the Annual Report and summary financial statement, in accordance with directions issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to report to you our opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements and the Directors' Remuneration Report and its compliance with the relevant requirements of the directions issued by Monitor.

We also read the other information contained in the Annual Report and consider the implications for our statement if we become aware of any apparent misstatements or material inconsistencies with the summary financial statement.

This statement, including the opinion, has been prepared for, and only for, the Board of Governors of Queen Victoria Hospital NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 (the Act) and for no other purpose. We do not, in giving this opinion, accept or assume responsibility for any other purpose or to any other person to whom this statement is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

The maintenance and integrity of the Queen Victoria Hospital NHS Foundation Trust website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements or summary financial statement since they were initially presented on the website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

We conducted our work in accordance with Bulletin 2008/3 issued by the Auditing Practices Board. Our report on the statutory financial statements describes the basis of our audit opinion on those financial statements, the Directors' Report and the Directors' Remuneration Report.

## OPINION

In our opinion the summary financial statement is consistent with the statutory financial statements and the Directors' Remuneration Report of the NHS Foundation Trust for the year ended 31 March 2010 and complies with the relevant requirements of the directions issued by Monitor.

We have not considered the effects of any events between the date on which we signed our report on the statutory financial statements (8 June 2010) and the date of this statement.

**Sarah Isted**
(Senior Statutory Auditor)

For and on behalf of
PricewaterhouseCoopers LLP
Chartered Accountants and
Statutory Auditors
London

14 July 2010

## DIRECTORS' STATEMENT

The auditors have issued unqualified reports on the full annual financial statements; the part of the directors' remuneration report that is described as having been audited; and on the consistency of the directors' report with those annual financial statements.

The auditors' report on the full annual financial statements contained no statement on any of the matters on which they are required, by the Audit Code for NHS Foundation Trusts, to report by exception.

# ANNEX A

# GLOSSARY

| | |
|---|---|
| Axillary and inguinal region block lymph node dissection | An operation to remove all the lymph nodes from the armpit or groin, which is the first area affected when a melanoma skin cancer starts to spread from the arm or leg. |
| Basal cell carcinoma | The most common form of skin cancer. |
| Brachial plexus anaesthesia | Local anaesthetics injected around the nerves supplying the forearm, either in the armpit or the neck. Frequently used in hand surgery to avoid the necessity of a general anaesthetic. |
| Comminuted digital fractures | A broken finger where the bone has fractured into several pieces. |
| Corneoplastics | A group of treatments and procedures to modify the cornea – the front part of the eye. |
| Curettage | A process for removing tissue. |
| Fat necrosis | A build up of dead fat tissue. |
| Free flap or free tissue transfer | The process of moving tissue from one part of the body to the other, requiring microvascular surgery to reconnect its blood supply. |
| Haematoma | A collection of blood (usually a blood clot) in body tissue, caused by bleeding from a damaged blood vessel. |
| Histology | Microscopic analysis of cells, used to diagnose cancer and other conditions. |
| Immuno-modulators | Natural or synthetic substances that help regulate or control the immune system. |
| Keratoplasty | A transplant to replace damaged tissue on the eye's clear surface. |
| Keratorefractive surgery | A procedure to change the shape of the cornea at the front of the eye to improve vision. |
| Lacrimal disorders | Eye problems related to the gland that produces tears. |
| Lamellar grafts | A type of corneal transplant using tissue from a donor eye. |
| Maxillofacial | Diseases affecting the mouth, jaws, face and neck. |
| Melanoma | A form of skin cancer. |
| Metastatic cancer | A cancer that spreads from its initial site to other areas of the body. |
| Microvascular surgery | Microscopic surgery on the smaller blood vessels in the body. |
| Mohs micrographic excision | Microscopically controlled surgery used to remove skin cancer |





| | |
|---|---|
| Oculoplastic | A wide variety of surgical procedures that deal with the eye socket, eyelids, tear ducts, and the face. |
| Oncology | The diagnosis and treatment of cancer. |
| Ophthalmic | The branch of medicine which deals with the anatomy, functions, and diseases of the eye. |
| Orthognathic surgery | Surgery to correct conditions of the jaw and face or to correct orthodontic problems that cannot be easily treated with braces. |
| Perioperative | Relates to the whole period of a patient's surgery, from ward admission, through anesthesia and surgery, to recovery. |
| Periorbita | The tissue surrounding the eye-socket. |
| Phacoemulsification | A surgical procedure to remove cataracts. |
| Pre-tibial lacerations | Damage or cuts to the front of the lower leg, which often fail to heal spontaneously. |
| Schwann cells | Cells that produce a protective substance surrounding nerve fibres. |
| Seroma formation | A common complication after breast surgery, in which a pocket of liquid forms. |
| Squamous cell carcinoma | A form of cancer. |
| Thromboembolism | A blood clot, which breaks off from where it forms, travels in the blood and lodges somewhere else in the body, for example, a deep vein thrombosis, causing a pulmonary embolism. |
| Thromboprophylaxis | The prevention of blood clots from forming, growing or spreading. |
| Tracheostomy | A procedure to create an opening in the neck leading directly to the wind pipe to bypass an obstruction, clean the airway or more easily deliver oxygen to the lungs. |
| Trapeziectomy | Removal of a small bone from the thumb joint to relieve the pain of arthritis. |
| Venous coupler | A device for re-connecting the blood supply to tissue moved through free flap transfer. |
| Wound dehiscence | A wound which unintentionally opens up after surgical closure. |

**Queen Victoria Hospital NHS Foundation Trust**

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