Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting

Hospital Boardroom
Chair: Prof. Sir Christopher Edwards
Date: 3 February 2010
Time: 4.30pm

Agenda

		Lead	Time
1	**GENERAL BUSINESS**		
1.1	Welcome & Apologies	CE	4.30
1.2	Declaration of Interests	CE	
1.3	Minutes of Previous Meeting held on 3 December 2009	CE	
1.4	Matters Arising	CE	
1.5	Chairman's Report (oral)	CE	
1.5.1	Results of election of the Deputy Chairman	CE	
2	**ITEMS FOR DISCUSSION/DECISION/APPROVAL**		
2.1	Strategy Update – presentation	HL	4.50
2.2	Business Planning (attached)	HL	5.05
2.3	Community Mobile Health Clinic – Projects (attached)	SN	5.20
2.4	Development of the Trust Website – presentation	MA/GV	5.30
2.5	Membership Sub-Committee		
2.5.1	Membership Sub-Committee report (draft minutes of 26 January 2010 meeting attached)	CB	5.40
2.5.2	Membership Report (attached)	SN	5.50
2.6	Quality Sub-Committee report (draft minutes of 20 January 2010 meeting attached)	CM	6.00
2.7	Funding Report (attached)	VD	
3	**ITEMS FOR INFORMATION**		
3.1	Finance Report – December 2009 (attached)	LB	
3.2	Performance Report – December 2009 (attached)	LB	
3.3	Care Quality Commission Registration (attached)	CM	
4	**ANY OTHER BUSINESS**		
5	**DATE OF THE NEXT MEETING** **21 April 2010**		

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 3 February 2010

AGENDA ITEM NO.	3.1/Feb/10
PAPER	Minutes of the meeting of the Council of Governors meeting held on 3 December 2009
AUTHOR	Vida Djelic, Interim Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper outlines a record of proceedings at the previous meeting.
DECISION/ ACTION	1. To agree the minutes as a correct record. 2. The Chairman to sign the minutes.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting Minutes, 3 December 2009

PRESENT:

Prof. Sir Christopher	Edwards	Chairman		CE
Walter	Balmford	Patient		WB
June	Bennett	Patient		JB
Chris	Birch	Patient		CBir
Christine	Blewett	Public	Hammersmith and Fulham 2	CBle
Nicky	Browne	Appointed	The Royal Marsden NHS Foundation Trust	NB
Cass J.	Cass-Horne	Patient		CC-H
Alan	Cleary	Patient		AC
Carol	Dale	Staff	Management	CD
David	Finch	Appointed	NHS Wandsworth	DF
Brian	Gazzard	Staff	Medical and Dental	BG
Rosie	Glazebrook	PCT	NHS Hammersmith and Fulham	RG
Jesus	Jacinto	Staff	Contracted	JJ
Martin	Lewis	Public	Westminster 2	ML
Catherine	Longworth	Appointed	Westminster PCT	CL
Duncan	Macrae	Appointed	Royal Brompton and Harefield NHS Trust	DM
Susan	Maxwell	Patient		SM
Wendie	McWatters	Patient		WMW
Ann	Mills-Duggan	Public	Westminster 1	AMD
Cyril	Nemeth	Appointed	Westminster City Council	CN
Jim	Smith	Patient		JS
Sue	Smith	Staff	Nursing and Midwifery	SS
Sandra	Smith Gordon	Public	Kensington and Chelsea 2	SSG
Mary	Symons	Public	Wandsworth 1	MS
Alison	While	Major Education Provider	King's College	AW

IN ATTENDANCE:

Charles Wilson	Non-Executive Director	CW
Mike Anderson	Medical Director	MA
Heather Lawrence	Chief Executive	HL
Andrew MacCallum	Director of Nursing	AMC
Catherine Mooney	Director of Governance and Corporate Affairs	CM
Vida Djelic	Interim FT Secretary	VD
Matt Akid	Head of Communications	MA

1 GENERAL BUSINESS

1.1 Welcome and Apologies

CE called the meeting to order and welcomed newly-elected governors and newly-appointed stakeholder representatives.

Apologies were received from Lucy Ball, Edward Coolen, Colin Glass, Sinead Jones, Duncan Macrae, Frances Taylor and Taryn Youngstein.

1.2 Announcement of results of elections

CE announced that the following were newly elected governors:

Public Governor:
Hammersmith and Fulham 2 – Christine Blewett (re-elected)

Patient Governors:
Cass.J.Cass-Horne
Alan Cleary
Edward Coolen
Susan Maxwell
Wendie McWatters
Jim Smith (re-elected)
Taryn Youngstein

Staff Members:
Allied Health Professionals, Scientific and Technical – Lucy Ball
Contracted – Jacinto Jesus
Medical and Dental – Brian Gazzard (re-elected)
Management – Carol Dale
Support, Administrative and Clerical – Sinead Jones

CE also welcomed two newly-appointed stakeholder representatives, Rosie Glazebrook of NHS Hammersmith and Fulham PCT and Alison While of King's College.

CE thanked both the current and new governors who attended the induction held on 24 November 2009 and said that he hoped that those who were unable to attend would have the opportunity to do it in the future.

CE asked those governors who attended the induction to complete the feedback form and return to VD so that she can process responses received and work on improving the future induction sessions.

CE added that VD will be arranging meetings with the Chief Executive and himself for new governors.

Vida Djelic to arrange. **VD**

1.3 Code of Conduct Acceptance

Members were asked to sign that they accepted the Code of Conduct upon arrival. **Those who were not in attendance will be contacted by VD to ensure all Governors have accepted the Code.** **VD**

1.4 Declaration of Interests

The Chairman gave a brief explanation about what the declaration involves and that any governor who has a material interest in any of the items that appear on the agenda should declare such interest to the Council of Governors and should withdraw from the meeting if relevant. This was in addition to the register of interests held by the Foundation Trust secretary.

The Chairman invited declaration of interests. None were tendered.

2 FOCUS ON QUALITY

2.1 What is Quality? – presentation

CE introduced the presentations. A task and finish group reviewing meetings had agreed amongst other things that a sub-committee of the Council be formed to address this issue.

CE said that Lord Darzi in 'High Quality Care for All' published by the Department of Health in 2008 focused on quality and identified three domains, safety, effectiveness and patient experience.

CM outlined the importance of quality as it saves lives, gets patients out of hospital quicker, makes being in hospital a better experience and is cost effective, allowing us to treat more patients. CM said that it is important that the Trust involves governors in the quality agenda in ensuring we get the priorities right, put initiatives in place in the right way, and communicate well. She said that quality accounts will be a legal requirement from April 2010. The format is not published yet due to ongoing consultation. Foundation Trusts were required by Monitor to include quality indicators in their annual reports this year.

MA focused on the Trust safety objectives and explained the importance of reducing preventable venous thromboembolism rate by 15% in the next year. He described the challenge of collecting data. Another objective was reducing in-hospital cardiac arrest and mortality through earlier recognition and treatment of the deteriorating patient, and the final objective was about reducing harm from

certain high risk medicines.

MA described the objectives relating to clinical effectiveness. He explained the Hospital Standardised Mortality Ratio (HSMR) and our objective to reduce it by 10%. MA pointed out that an average hospital has 100 deaths and that if the figure is below 100 that would indicate that the hospital concerned is having less deaths than expected.

2.2 Registration with the Care Quality Commission

CM informed the Council of Governors that registration replaces a declaration on compliance with core standards. CM said that the full guide regarding registration is not published yet.

2.3 The assessment of quality (patient experience)

AMC presented on patient experience as a part of Trust quality objectives. He said that the Trust needs to ensure that 90% of women have an excellent experience of its maternity services. It is also important to achieve a progressive improvement in key issues identified in the annual patient survey and to reduce the number of complaints relating to appointments and admissions.

AMC said that the Trust has a number of steering groups which will make sure that the Trust moves in the right direction. He emphasised that it is important to identify patients' opinions. Last year, overall 94% patients rated their care as good, very good or excellent. However, we wished to do better. An example of acting on concerns was addressing noisy wards at night, but on further consideration it was identified that the real issue was a good night's sleep.

He described the patient experience tracker which was an electronic console which allows patients to answer up to 5 questions. The answers get collected electronically and the advantage of using the patient experience tracker is getting the real time feedback.

AMC pointed that in addition to the national patients survey the Trust also surveys patients about specific services, and the Trust has a comment card scheme. Comment cards are distributed throughout the Trust.

AMC emphasised that the Trust is committed to capturing the patient's experience. The Chelsea and Westminster Hospital now records and tracks actions taken in response to complaints to ensure that changes are made.

CE invited questions and comments.

AC expressed doubt about whether patients' responses were likely to be an honest reflection of their experience. AMC pointed out that information from the patient tracker was anonymous.

MA said that for a long time specialities looked at quality individually but now the issues that are being picked up are Trust wide and if we get them right we will save lives. As an example he described the enthusiasm and commitment of the consultant haematologist who was addressing issues around blood clots.

2.4 Quality Sub-Committee Terms of Reference

CM said that Quality Accounts will be required as part of legislation from April 2010 and that stakeholder involvement was key. The aim of the Quality Sub-Committee was to take on board the views and expertise of the Trust governors. She outlined the terms of reference and asked for comments.

It was suggested that developing agreed metrics was an important function of the Group. MS queried why the terms of reference were so inflexible i.e. they could not be changed without the Council approving. CE said this should not limit innovation in practice if a pragmatic approach was taken.

HL noted that an important link was to the Assurance Committee who considered quality on behalf of the Board.

CE said that as a principle, non Council members should be in attendance rather than members. CM said that this had been agreed by the Communication sub group but it was not a principle that had been agreed for all sub-committees. CE felt that key people would be disenfranchised if not members of the group.

WB raised the question if the Chairman of this group should be a member of the Council of Governors. CM said that it was suggested that the meeting is chaired initially by one of the Executive Directors to provide the necessary insight into the quality legislation and relevant background from the Trust and then a governor could take over once the sub-committee is fully established.

CE noted that the quorum will comprise of three Governors and at least one Director.

JS felt that it is very important to have a patient representative on the quality sub-committee. NB agreed that the patient representative is important and that other stakeholders such as the PCT have other mechanisms of providing input. CM pointed out that it would also be good to have a PCT representative as this will be the key sub-committee.

CE then invited governors to volunteer and send their responses to VD.

Volunteers to e-mail VD. **All**

SSG said that everybody from the Council of Governors is welcome to attend these meetings and that there should not be a limit to the number on each committee.

AC asked if this sub-committee would vote. CE explained that the sub-committee make proposals but they do not vote.

The Terms of Reference were agreed subject to incorporating the suggestions above.

3 PREVIOUS MEETING

3.1 Minutes of Previous Meeting held on 17 September 2009

These were agreed as a correct record of proceedings. CE pointed out a typo on the p.7 ‘18 Dean Street’ should read ‘56 Dean Street’.

3.2 Matters Arising

The meeting noted the actions and subsequent outcomes.

CE explained to new governors that at the last meeting there was a particular issue regarding the start time of meetings as CBir had noted that the meeting times might disadvantage some governors. The FT Secretary surveyed governors after the September Council of Governors meeting. CM said that VD will survey both new and existing governors to establish what would be the most preferred start time of meetings. She will offer 4.30pm and 6pm. Once the exercise has been completed VD will confirm the final dates and times.

VD to survey members to determine the start time for the future meetings. VD

4 REPORTS AND OTHER ITEMS FOR DISCUSSION/DECISION/APPROVAL

4.1 Chairman's Report (oral)

CE said that he wanted to congratulate staff, in particular HL for getting an excellence rating for both quality of services and financial management. CE also expressed his thanks to the Trust for getting a top banding of 5 out of 5 for patient safety by the Dr Foster Hospital Guide and for being ranked as the 4th best NHS Trust in England. CE said that the Chelsea and Westminster Hospital has done very well and that the Trust is in line with Royal Marsden and Royal Brompton and Harefield Hospital which also scored double excellence. He said that the Trust should be proud of its achievements.

4.1.1 Election incident

CE reported to members on an incident relating to the election of a governor in November 2007, further details of which were in the paper. CE said that a number of errors occurred, none of which were anticipated. As a consequence one of the governors had to leave the Council of Governors as he was not eligible.

CBle arrived.

CE said that there were two options. One is that the Trust undertakes a further election for a governor for Hammersmith and Fulham 1 next year and the other is to take the highest polled candidate to join the Council of Governors. CE suggested the Trust includes an election for a governor for Hammersmith and Fulham 1 next year when it holds elections for Wandsworth 2 and Kensington and Chelsea 1.

CBir said that the Trust should write to MB and to explain the mistakes that had occurred. CE said that we had apologised profusely and unreservedly to MB, had explained the errors that had occurred and had thanked him for his contribution over the last two years. In addition CE had met with MB.

The Council agreed to the election of a governor for the three areas in 2010.

4.2 Election of Deputy Chairman of Council of Governors

CE introduced the paper.

The role of the Deputy Chair is described in the constitution in section 10.11.

CM clarified that Deputy Chairman of the Council of Governors may deputise for the Chairman at an annual members' meetings but that the Vice Chairman of the Board would deputise at the Council of Governors meetings. The latter is part of the model constitution but the former could be changed.

CM also said that Monitor had written to all chairs of FTs regarding the lead governor and the role was described. She suggested that the Deputy Chairman could also be the lead governor.

CE clarified that if the Chairman of the Council of Governors was unwell then the Council meeting would be chaired by the Vice Chairman of the Trust Board (Charlie Wilson); but in a similar situation at the annual members meeting, then the Deputy Chairman of the Council would chair the members' meeting.

CBir congratulated CM for being able to make this clear but it seemed a bit odd and he suggested that this should be considered in a review of the constitution

JB suggested that if we were looking at the constitution we should also look at the need to have two members for each borough.

CW pointed out that he thought that the constitution was a matter for the Trust Board. CE said there was a need for a dialogue between the Board and the Council.

Nominations for a Deputy Chairman should be forwarded in writing to the Chair (or via email to vida.djelic@chelwest.nhs.uk) by 31 December 2009. **All**

4.3 Report back from sub-committee

4.3.1 Communications sub-committee report

CBir said that there were two minor mistakes on the cover sheet of the draft minutes. In the paper section it should read 'Council of Governors' and in the decision/action section it should read 'for information' as the draft minutes get accepted by the Communications Sub-Committee.

CBir outlined some of the proposals from SN e.g. updating contact details and the idea of creating a young person's governor which is at a very early stage.

CE pointed out that the Trust has a very small number of young patients and he hoped that with the expansion of the building the Chelsea and Westminster Hospital can develop more interest from young people. CBir asked if there was restriction as to the age in the constitution. CM said it was 16.

4.3.2 Membership report

SN introduced the membership report. She said that there was a strong representation between the age 41 and 65 but not so much in other areas. She noted the ethnicity in the public constituency and as in the previous reports the white ethnicity dominated.

SN reported that the Trust had successfully completed the election process. She pointed out that the table under 3.2 should read Hammersmith and Fulham Area 1. SN said that all of staff seats were successfully filled.

SSG pointed out that the figures on table 1 did not add up correctly. There was also a query on the socio-economic groupings. SN said that these were based on post codes. Socio-economic grading is assessed by occupation. Capita uses the dominant social grade for a postcode area based on the Census Output Area for Great Britain. This is accepted by Monitor.

RG said that the ethnicity groupings are not the same as is used elsewhere in the Trust and was interested in how we are targeting black and Asian members. SN said some were unknown and that the Trust is encouraging members to complete their ethnicity. WMW felt that it was very important to use the media, local press and other opportunities to make the hospital prominent.

SN to clarify figures and ethnicity groupings. **SN**

4.3.3 Membership development and communication work plan

SN said that she has developed an annual work plan with the intention to continue to achieve an increase in membership. The annual work plan had been presented to the Council of Governors and was approved at its September's meeting.

SN outlined a number of ways in which the Trust engages members interest and in particular that the Trust had rebranded PALS to M-PALS, the use of comment cards, and improved collaboration with Chelsea and Westminster Hospital Healthcare Charity

NB said she had had an informal meeting with the Healthcare Charity. The Trust uses their resources but they cannot use ours. SN suggested that there should be one governor who should explore the ideas of working together with the Charity. CE suggested that the Trust should invite the Healthcare Charity to its meeting next year.

SN said that Annual Members' Meeting held in September was successful overall and that the Trust was able to inspire members to stand for elections.

AW suggested that the Trust get a small card asking outpatients if they want to be a member. SN said that the MPALS Officers have taken leaflets to out-patients areas and encourage staff to promote membership.

4.4 Term of office of Chairman

This item was taken as read and agreed.

4.5 Terms of Reference Communications Sub-Committee

A tabled version of the paper including the track changes was circulated.

CBir clarified that Membership Development Sub-Committee used to be called the Membership Development and Communications Sub-Committee. He suggested it be called the Membership Sub-Committee. The Council of Governors agreed.

4.6 Agreement on Meeting Dates and Time

SSG asked if there should be a Council of Governors meeting in September and

December. It was agreed that VD will send the final dates to the Council of Governors.
VD to send final dates. **VD**

4.7 Council of Governors Funding Report

CM said that there is an additional charge of £115 for the computer items which relates to VAT, that was not originally factored in when the report was agreed by the members at its meeting on 17 September 2009. It was agreed that this was funded.

The Council of Governors approved £15,000 funding for Open Day 2010.

5 ITEMS FOR INFORMATION

5.1 Membership of Sub-Committees and Trust Groups

This item was taken as read.

5.2 Agreement of Annual Cycle of Business

This item was taken as read.

5.3 Finance Report – October 2009

This item was taken as read.

5.4 Performance Report – October 2009

This item was taken as read.

5.5 Notes from Chief Executive's Strategy Workshop

This item was taken as read.

5.6 Foundation Trust Governors' Association Annual Report 2008/09

This item was taken as read.

5.7 Who is who on the Council of Governors?

This item was taken as read.

5.8 Invitation to work with the Care Quality Commission

This item was taken as read.

6 ANY OTHER BUSINESS

CBir said that he wished to highlight the extent to which the medical staff is involved in the decision making process, strategic planning and developing of the Trust. HL said that the Medical Staff Committee will discuss these issues.

7 DATE OF THE NEXT MEETING

11 February 2010

Post-meeting note: Since the last meeting it has become necessary to rearrange the next meeting to 3 February 2010.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 3 February 2010

AGENDA ITEM NO.	1.4/Feb/10
PAPER	Matters Arising from the meeting of the Council of Governors meetings held on 3 December 2009
AUTHOR	Vida Djelic, Interim Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper lists matters arising from previous meeting and the action taken or subsequent outcomes.
DECISION/ ACTION	The Council of Governors is asked to note the matters arising and the updates.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

MATTERS ARISING
Council of Governors Meeting

Hospital Boardroom
Chair: Prof. Sir Christopher Edwards
Date: 3 December 2009
Time: 4:30 – 6:30 pm

Ref	Description	Lead	Subsequent Actions or Outcomes
1.2	**Announcement of results of elections**		
	CE added that VD will be arranging meetings with the Chief Executive and himself for new governors. **Vida Djelic to arrange.**	**VD**	**Completed**
1.3	**Code of Conduct Acceptance** Members were asked to sign that they accepted the Code of Conduct upon arrival. **Those who were not in attendance will be contacted by VD to ensure all Governors have accepted the Code.**	**VD**	**Completed**
2.4	**Quality Sub-Committee Terms of Reference**		
	CE invited governors to volunteer for the sub-committee and send their responses to VD. **Volunteers to e-mail VD.**	**All**	**Completed. Volunteers: Walter Balmford, Chris Birch, Carol Dale, Rosie Glazebrook, Martin Lewis, Susan Maxwell, Wendie McWatters, Cyril Nemeth, Jim Smith and Sandra Smith-Gordon.**

3.2	**Matters Arising** **VD to survey members to determine the start time for the future meetings.**	**VD**	**Completed. Agreed 4.30pm**
4.2	**Election of Deputy Chairman of Council of Governors** **Nominations for a Deputy Chairman should be forwarded in writing to the Chair (or via email to vida.djelic@chelwest.nhs.uk) by 31 December 2009.**	**All**	**Completed. 3 Governors were nominated. An e-mail regarding election undertaken and Brian Gazzard was elected with a vote of 16.**
4.3.2	**Membership report** RG said that the ethnicity groupings is not the same as is used elsewhere in the Trust and was interested in how we are targeting black and Asian members. SN said some were unknown and that the Trust is encouraging members to complete their ethnicity. WMW felt that it was very important to use the media, local press and other opportunities to make the hospital prominent. **SN to clarify figures and ethnicity groupings**	**SN**	
4.6	**Agreement on Meeting Dates and Time** SSG asked if there should be a Council of Governors meeting in September and December. It was agreed that VD will send the final dates to the Council of Governors. **VD to send final dates.**	**VD**	**Completed.**

Council of Governors Meeting, 3 February 2010

AGENDA ITEM NO.	2.2/Feb/10
PAPER	Business Plan 2010/11 and Corporate Deliverables
AUTHOR	Amit Khutti, Director of Strategy & Planning
LEAD	Heather Lawrence, Chief Executive
EXECUTIVE SUMMARY	This paper sets out the overall framework and timeline of business planning, asks for the Council of Governors feedback on the Corporate Objectives for 2010/11, and sets out the highlights of the Operating Framework for the NHS in 2010/11. We are recommending maintaining the three high-level Corporate Objectives from 2009/10: 1. Improve patient safety and clinical effectiveness 2. Improve the patient experience 3. Deliver excellence in teaching and research. The Board has also agreed to add an additional fourth high-level objective which addresses both the efficiency and sustainability agendas, provisionally titled '*Ensure Financial and Environmental Sustainability*'.
DECISION/ ACTION	The Council is asked to feedback on the proposed corporate objectives for 2010/11.

BUSINESS PLANNING 2010/11-12/13 AND CORPORATE DELIVERABLES: COUNCIL OF GOVERNORS

CONTEXT

This paper has three key purposes:

1. to set out the overall framework and timeline for business planning for 2010/11-2012/13;
2. to update the Council of Governors on the setting of Corporate Objectives for 2010/11;
3. to update the Council on the implications of the recently published Operating Framework for the NHS in 2010/11 which sets out the priorities for the NHS and details of changes to how we will be paid for the services we deliver .

1. OVERALL FRAMEWORK AND TIMELINE FOR BUSINESS PLANNING 2010/11-2012/13

The planning cycle for 2010/11-12/13 has commenced and each directorate will be meeting with the Executive Team in three bilateral meetings (January, February, March) to review, challenge and agree their future plans, including ensuring alignment with the corporate strategy and objectives.

As in previous years, directorates will be expected to take an integrated approach engaging all staff groups in the planning process. Clinical directors will again lead jointly with general managers, with support from the relevant departments such as HR and finance and directorates will again also be expected to engage other services and directorates where there is appropriate crossover.

Directorates will be expected to demonstrate that they have involved different staff groups in planning by holding interdisciplinary meetings with clinical, medical, support and administrative staff.

We are proceeding on the basis of planning based on directorates for now. In February we will be asking the newly appointed Divisional Medical Directors and Divisional Operational Directors to take an overview and to sign off the plans.

A detailed timeline at the end of this paper sets out key dates and milestones for the overall business planning process.

Purpose of business planning

Business planning will culminate in the production of the Trust's Annual Plan for 2010/11 which is published by Monitor, as well as more detailed directorate business plans and budgets which are for our internal purposes.

Our Trust Annual Plan should:

- Set out a clear direction of where the Trust is heading, as described by the Board;
- Highlight key objectives that will be delivered in the next 3 financial years;
- Show how the Trust will align resources to deliver these objectives;
- Set out risks to delivery of these objectives;
- Be a mechanism by which Monitor – the Foundation Trust regulator – holds the Trust Board to account.

As individual directorate business plans are developed, they will be expected to show how they will contribute to the overall delivery of the Trust annual plan.

2. CORPORATE OBJECTIVES FOR 2010/11

The corporate objectives and deliverables for 2010/11 were discussed by the Board on the 27th of January 2010.

We believe that we should maintain the high level objectives agreed in the 2009/10 annual plan as they reflect the NHS priorities set out in the *Next Stage Review* of the NHS, they are flexible enough to accommodate our key priorities but also provide continuity of focus to our staff.

The high level objectives are as follows:

- Improve patient safety and clinical effectiveness
- Improve the patient experience
- Deliver excellence in teaching and research

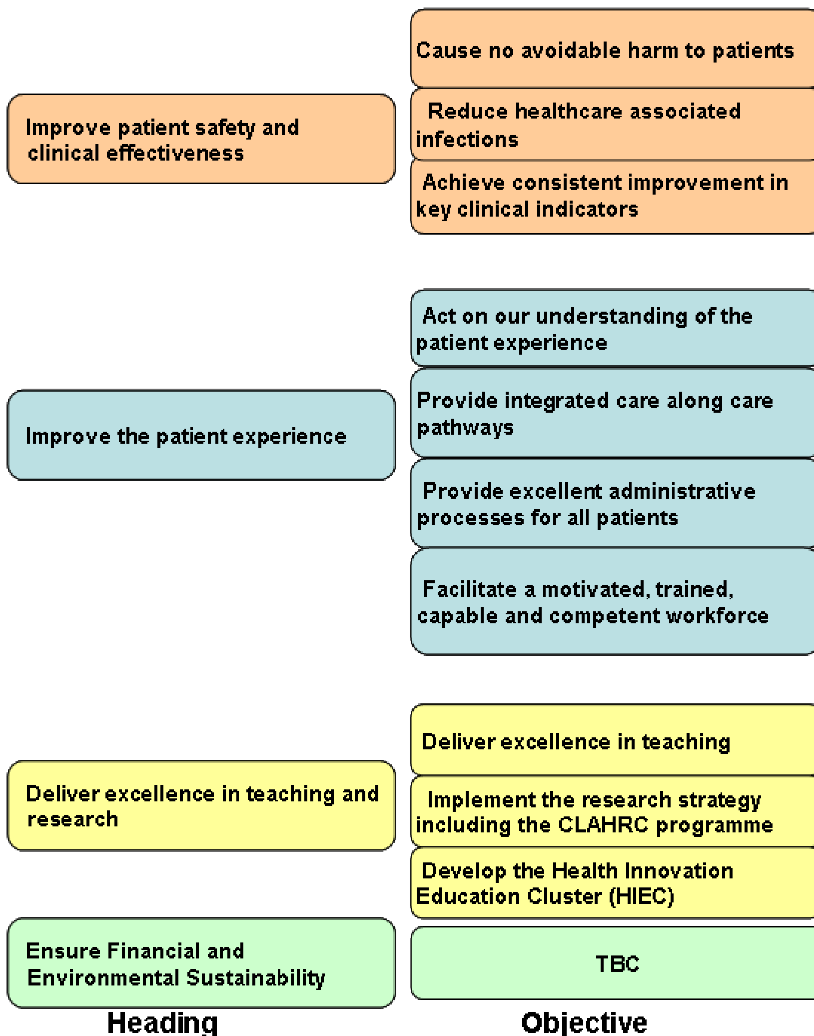
Given the likely future financial environment, the Board discussed adding a high-level objective that focuses on driving productivity and efficiency. At the same time, the sustainability agenda (e.g. low-carbon future including reducing energy consumption, reducing waste, conserving water) is rapidly rising up as an NHS priority, and the Board considered this adding an additional objective that reflects the need to improve our performance on operating sustainably.

The 2009/10 Corporate Objectives and specific deliverables are set out below.

Heading	Objective	2009/10 Deliverable
Improve patient safety and clinical effectiveness	Cause no avoidable harm to patients	Define patient saftey indicators with local targets and design measurement system
	Reduce healthcare associated infections	No elective patient infected with MRSA bacteraemia whist in the hospital
	Achieve consistent improvements in patient safety indicators	Define clinical indicators with local targets and design measurement system
Improve the patient experience	Develop methods to understand and improve the patient experience	90% of women have an excellent experience in maternity services.
		Achieve progressive improvement in key issues identified in the patient survey
	Provide excellent administrative processes for all patients	Develop an improvement in key areas of administrative efficiency as measured by reduction in complaints related to appointments & admissions
	Facilitate a motivated, trained, capable and competent workforce	Increase staff satisfaction by achieving 100% of staff completing appraisals and PDPs and a year-on year improvement in sickness, vacancy rates and uptake of mandatory training
Deliver excellence in teaching and research	Deliver excellence in teaching	Deliver an agreed improvement in students' overall rating of their teaching
	Develop the research strategy including the CLAHRC programme	Complete strategy to include how to enhance the research profile and income and deliver the CLAHRC programme
	Achieve status as a hub for Health Innovation Education Cluster (HIEC)	Achieve status as a hub for Health Innovation Education Cluster (HIEC)

Decision of the Board:
To limit the number of high-level objectives and to thus keep them memorable to staff, the Board agreed to add one additional high-level objective for 2010/11 that combines elements of the efficiency and sustainability agendas into a single objective. The provisional title of this new high-level objective is **'Ensure Financial and Environmental Sustainability'**.

We are proposing to maintain most of the same second tier objectives as well (see below), and the Executive team will need to agree specific deliverable targets against each objective and bring them back for approval to the Board in March. We are proposing to add one new second tier objective under 'Improve the patient experience' – which is to 'Provide integrated care along care pathways'. Given the emphasis on implementation of *Healthcare for London* including developing care pathways that cross organisations, we feel that this emphasis on the provision of coordinated care regardless of setting should be an area of focus for the Trust. We will also need to determine second tier objectives to fit under the new high level objective of 'Ensure Financial and Environmental Sustainability'.



***For discussion*:**
The Council of Governors are asked to provide feedback on the high-level and second-tier objectives set out above.

3. HIGHLIGHTS OF THE OPERATING FRAMEWORK 2010/11

The recently published Operating Framework for the NHS in England 2010/11[1] sets out the priorities for the NHS for next year and also underlines the increasing focus on efficiency, productivity and integration of care that is to be expected over coming years.

The Framework confirms that 2010/11 is the last year of growth in NHS funding before entering a much tougher financial environment than the NHS has known in a long time, with David Nicholson reaffirming that the NHS needs to find £15-20bn of efficiency savings by 2013/14 to reinvest in the service. The Framework underscores the importance of acting in 2010/11 whilst there is still some additional money in the system, to prepare for the tougher future environment.

The Framework does not set new national targets, and instead confirms that the five current national priorities will remain important for the NHS overall:

- **Cleanliness and healthcare associated infections**:
  - Further to go for poorer performing organisations on MRSA and *C difficile;*
  - An expectation that providers screen all relevant emergency admissions;
- **Access to services**:
  - Delivering18 weeks from referral to treatment in all specialties, which will eventually become a legal right under the NHS Constitution;
  - Extended GP opening hours;
- **Keeping people healthy and reducing health inequalities**:
  - a focus on identifying cost-effective preventative interventions;
  - more progress on stroke care including access to stroke units and brain scans within one hour of admission;
- **Improving patient experience and staff satisfaction and engagement**:
  - Patient experience to be built into the payments available through the CQUIN (Commissioning for Quality and Innovation) scheme;
  - Implementing the findings of the Boorman review *NHS Health and Wellbeing 2009*[2] leading to reduced sickness and absence;
- **Emergency preparedness**:
  - Reviewing, testing and updating flu plans;
  - Putting in place and testing plans for other major incidents such as terrorist attacks, flooding and chemical, biological, radioactive and nuclear (CBRN) threats.

Although the framework does not set new national priorities, it does make significant changes to the **system levers** that are available to incentivise different ways of working.

Success is partly defined in terms of the NHS in five years' time having "more services closer to home and therefore less investment and activity in the acute sector". The desired characteristics of the new system would include:

- More care closer to home;
- Fewer acute beds;

[1] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107
[2] http://nhshealthandwellbeing.org/

- Reduced unit costs;
- Reduced variation;
- More standardisation of pathways;
- Early and more upstream intervention; and
- Greater co-production, with people taking greater ownership of their health.

The key **system levers** are set out below under the headings Financial Framework, Income/Tariff, Workforce, and Commissioning/System Reform:

Financial framework
PCTs will receive an average growth in allocated funds of 5.5% with a minimum floor growth of 5.1%; PCTs have been told to plan for flat real revenue allocations growth (e.g. inflation only) for the years 2011/12 and 2012/13.

However, there are a number of factors that complicate the apparently significant growth being put into PCT funds.

First, given the overall state of the public finances, there is a strong possibility that the levels of funding going into the NHS will need to be reviewed by any government post-election. For the NHS to continue to receive flat real allocations growth, other government departments would likely need to take significant cuts in spending; if hospitals, schools and the police are protected, other departments could face significant year-on-year cuts in funding which would be politically challenging to deliver.

Second, within the growth given to PCTs they must still deliver a 1% surplus and have, for the first time, been asked to keep back 2% of their funding for non-recurrent use to support one-off service set up costs and redeployment/redundancy costs.

Income/Tariff
Key for our financial planning is the impact of proposed changes to the tariff.

The Payment by Results tariff will continue using HRGv4, and the tariffs for A&E services – which are not currently under HRGv4 - will continue to use the existing tariffs rather than migrate to HRGv4.

The headline tariff price changes are:

- 0% uplift in national tariff prices, and uplift for the following three years a maximum of 0%;
- 3.5% efficiency requirement built into the tariff;

Table 1 below sets out how the Department of Health has arrived at this headline uplift of 0% in national tariff prices.

Table 1: 2010-11 tariff uplift

	%
Pay	2.0
Non-pay inflation	0.6
Non-pay pressures	0.9
Efficiency	-3.5
Tariff uplift	**0.0**

Significant changes to the payment mechanisms include:

- Emergency activity above the 2008-09 activity levels (outturn) will only be reimbursed at ***30%*** of national tariff. This significant change is intended to incentivise acute providers to work with others to manage emergency demand;
- Our Market Forces Factor (MFF) which has historically been one of the highest in the NHS – and acts as a 'top-up' to our basic PbR tariff – will reduce by a further 2%;
- CQUIN schemes will rise from being worth 0.5% of total contract income (£1.1m for C&W in 2009/10) to 1.5% of total contract income, and the quality schemes to which they are attached will include a patient experience element.

Other tariff changes that have been flagged include:

- The introduction of four best practice tariffs for cataracts, cholecystectomy (gall bladder removal), fragility hip fracture and stroke;
- Combining elective and day case tariffs where appropriate;
- Mandatory tariffs for a limited number of outpatient procedures with the remainder to be reimbursed as part of mandatory outpatient attendance tariffs;
- Re-bundling of diagnostic imaging with outpatient attendance except for direct access;
- Removal of the short stay elective tariff - except for a small number of HRGs;
- Exclusion of HRG WA14Z (planned procedures not carried out) from the scope of the mandatory tariff;
- No payment for NPSA 'never events' such as wrong site surgery and wrong route of administration of chemotherapy.

Future changes that have been trailed and may become significant in time are:

- After 2010/11, moving to a position where national tariffs represent the maximum price payable by a commissioner, as opposed to the mandated price for particular activity;
- A review of the methodology for calculating the specialist orthopaedic and children's services top-ups for 2011/12.

Workforce

The NHS Pay Review Body has confirmed that it will not seek a remit to review the pay increase for the final year of the three-year pay deal for Agenda for Change staff in 2010/11. The Department has recommended that consultants and very senior managers receive no increase for 2010/11.

SHAs and their respective PCTs must meet an aggregate target reduction of 30 per cent in management and agency costs by 2013/14.

In terms of education and training, the Department will issue details of the MPET (Multi-professional Education and Training) review that will introduce improved metrics and the equivalent of a tariff for education to incentivise and reward quality. The phased implementation of this review is likely to start from April 2011.

NHS London is already moving ahead with a scheme to separate the commissioning and provision of education in London, and will be introducing a more transparent tariff-based system which will

by October 2010 let contracts worth ~20% (~£55m) of Postgraduate Medical and Dental Education & Training funds to a series of Lead Providers who will be designated by NHS London to work with Local Education Providers (such as our Trust) to manage these funds and the effectiveness of education and training within a region. We are exploring what role our North West London Health Innovation and Education Cluster should play in this education commissioning system.

Commissioning and System Reform

PCTs are being encouraged to commission "transformed and integrated pathways to optimise health gains and reduce health inequalities". We can expect to see PCTs experimenting with commissioning pathways of care that cross organisations, particularly when with individuals with long-term conditions (e.g. diabetes), and will need to plan how we respond to these developments.

For providers, the DH has said it will simplify and accelerate the assessment and approval of mergers, acquisitions and joint ventures.

How are we reacting to the changed strategic context in this year's business planning?

The following key messages have been sent out to the Directorates to inform their planning based on the tougher financial environment we will face and on key messages contained in the Operating Framework for the NHS:

- We need to prepare now for tougher financial times in future, by making significant efficiency and productivity improvements before money gets tighter;
- We should be prudent and strive for higher efficiencies than we might otherwise given future uncertainties such as whether a post-election government will revisit the overall NHS finances or how we would be positioned to compete in a world where the national tariff was a maximum price;
- However, the focus on quality (patient safety, clinical effectiveness, patient experience) embedded in the NHS *Next Stage Review* is still very relevant, as evidenced by the increased proportion of income related to CQUINs. We will need to find ways to improve quality whilst reducing costs;
- There will be a strong drive from commissioners to move services out of hospital and into the community and we need to start being proactive in responding to this drive;
- We cannot rely on growing our way out of trouble – although this might be feasible in some services, overall we know that commissioners are looking to shift significant funds away from acute services over the next few years;
- We need to prioritise our developments and to ensure they reflect the need for greater efficiency and productivity;
- We need to review our workforce skill mix;
- We need to review our administrative practices.

	December 2009		January 2010		February 2010		March 2010	
	29				31			
Monday	30				1		1	
Tuesday	1				2		2	
Wednesday	2				3	**Council of Governors**	3	
Thursday	3	Members' Council			4	**Business Cases due to IMG**	4	
Friday	4		1		5		5	
Saturday	5		2		6		6	
Sunday	6		3		7		7	
Monday	7		4		8		8	
Tuesday	8		5		9		9	
Wednesday	9		6		10	**All submit completed templates including directorate objectives**	10	***3rd Bilaterals - Signoff with Directorates (in blue)***
Thursday	10	Publish activity planning templates	7		11	***Investment Management Group x2 (in orange)***	11	
Friday	11		8		12		12	
Saturday	12		9		13		13	
Sunday	13		10		14		14	
Monday	14		11	**Submit frontline draft directorate activity plans, Cost Pressures, investments & CIPs**	15	Mon Execs: Signoff of 3 year Plan	15	Executive Signoff of Annual Plan; Deadline for signing contracts
Tuesday	15		12		16	Finance Investment Committee	16	Finance Investment Committee
Wednesday	16		13	***1st Directorate Bilaterals (in blue)***	17	***2nd Directorate Bilaterals (in blue)***	17	
Thursday	17	Board of Directors (agree high-level Corporate Objectives)	14	Review first cut income position using road test tariffs	18	Contract Review mtg with Commissioning Partnership	18	Contract Review mtg with Commissioning Partnership
Friday	18		15	**Other departments submit templates**	19		19	
Saturday	19		16		20		20	
Sunday	20		17		21		21	
Monday	21	Contract Review mtg with Commissioning Partnership	18		22		22	
Tuesday	22	Publish Business Planning guidance & templates	19	Contract Review mtg with Commissioning Partnership Finance Investment Committee	23		23	
Wednesday	23		20		24		24	
Thursday	24		21		25		25	Board of Directors (Annual Plan signoff)
Friday	25		22		26	Agree Contract with Commissioning Partnership	26	
Saturday	26		23		27		27	
Sunday	27		24		28		28	
Monday	28		25				29	
Tuesday	29		26				30	
Wednesday	30		27			***Investment Management Group x2 (in orange)***	31	Annual Plan to be finished
Thursday	31		28	Board of Directors (update on Plan)			1	Start of new financial year
Friday			29					
Saturday			30					

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 3 February 2010

AGENDA ITEM NO.	03/Feb/10
PAPER	Membership Recruitment Through Involvement with a Mobile Community Health Clinic
AUTHOR	Sian Nelson, Membership and Engagement Manager
LEAD	Andrew MacCallum, Director of Nursing
SUMMARY	The Sexual Health / HIV Directorate have secured charitable funding to pilot a mobile community health clinic for six months. It is proposed as part of this project to actively recruit people attending the clinic to the hospital's membership. With the agreement of Chelsea Football Club the mobile clinic will be launched at Stamford Bridge on Sunday 7th February 2010 (Chelsea -v- Arsenal) and will provide a health screening service. The Members Council is asked to support the funding of the "Campaign Company" to provide recruiters who will be available to recruit people to the Hospital's membership on 7th February when the Mobile Clinic is launched and at football matches over the season.
DECISION/ ACTION	The Council of Governors is asked to support the membership recruitment costs from their allocated budget. The total cost is £3,539.10.

Membership Recruitment
Through Involvement with a Mobile Community Health Clinic

Introduction

The Sexual Health / HIV Directorate have secured charitable funding to pilot the use of a custom built Mobile Community Health Clinic. During the pilot Hammersmith & Fulham PCT has agreed to pay for the clinical activity undertaken in the mobile clinic.

The mobile clinic will be used to carry out general and sexual health screening (e.g. blood pressure, urine testing for glucose (diabetes), HIV and sexual transmitted infections). There will be onward medical referral and follow up, if required, of patients either where people live or at Chelsea and Westminster Hospital.

Chelsea Football Club has agreed that the mobile clinic can be used on match days at Stamford Bridge during the current football season.

On Sunday 7th February 2010 the mobile clinic will be launched and it is anticipated there will be a good deal of media attention from newspapers and television.

John Hollins, former footballer and manager with his son Chris Hollins, a BBC sports reporter and the current Strictly Come Dancing champion, will be attending the launch event.

Membership Recruitment

It is proposed that the Hospital actively recruits people who use the mobile clinic to the Hospital's membership. This type of recruitment has two advantages. It is anticipated that there will be an opportunity to recruit young men attending football matches who are currently not well represented within the Hospital's membership. Also people who may not have come into contact with the Hospital's services but who may be eligible for membership may be attracted to join.

The Proposal

It is proposed that the Council of Governors approves the funding of membership recruiters (The Campaign Company) who would be available to recruit new members (patients and public) when the mobile clinic is open for business at Chelsea Football Club.

Costs

Three recruiters for 7 x 4 hour sessions	£1,512.00
Set up costs i.e. publicity materials	£1,500.00
Sub Total	£3,012.00
VAT @ 17½%	£527.10
Grand Total	**£3,539.10**

The use of the mobile health clinic will be evaluated and, if successful, may be used in the future to reach people who for whatever reason find it difficult to access health screening services. This would offer future recruitment opportunities to the Council of Governors.

The Council of Governors is asked to approve this funding for this membership campaign, linked to the Trust's pilot of a Mobile Community Health Clinic.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 3 February 2010

AGENDA ITEM NO.	2.5.1/Feb/10
PAPER	Draft minutes of the meeting of the Council of Governance Membership Sub-Committee held on 26 January 2010
AUTHOR	Vida Djelic, Interim FT Secretary
LEAD	Chris Birch, Chairman
SUMMARY	This is a draft of proceedings at the meeting held on 26 January 2010
DECISION/ ACTION	The meeting is asked to note the draft minutes.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Membership Sub-Committee, 26 January 2010

Draft Minutes

Attendees	Chris Birch	CB	Chairman
	June Bennett	JB	Patient Governor
	Jim Smith	JS	Patient Governor
	Wendie McWatters	WMW	Patient Governor
	Sandra Smith Gordon	SSG	Public Governor – Kensington & Chelsea 2
In attendance	Sian Nelson	SN	Membership and Engagement Manager
	Matt Akid	MA	Head of Communications
	Andrew MacCallum	AMC	Director of Nursing
	Catherine Mooney	CM	Director of Governance and Corporate Affairs
	George Vasilopoulos	GV	Web Communications & Graphic Design Manager
	Matthew Whiting	MW	PALS Officer
	Vida Djelic	VD	Interim FT Secretary

1 Welcome and Apologies **CB**

CB welcomed WMW to her first meeting of the sub-committee and asked members to introduce themselves.

SN asked the sub-committee to agree that Matthew Whiting, PALS officer, could join the sub-committee meetings as a representative from PALS. The sub-committee agreed.

Apologies were received from Jane Tippett and Renae McBride.

2 Results of election of the Chairman of the Membership Sub-Committee **VD**

VD said that following her e-mail to the membership sub-committee of December 2009 inviting nominations for the Chairman of the Membership Sub-Committee she only received a nomination of Chris Birch. She therefore announced that Chris Birch was elected as the Chairman of the Membership sub-committee.

CB referred to the terms of reference of the sub-committee and asked the sub-committee to confirm his election. This was agreed. CB said that he was honoured to be the Chairman of the Membership Sub-Committee.

3	**Minutes of previous meeting 10 November 2009**	**CB**

Minutes of the previous meeting were accepted as a true and accurate record of the meeting with the following changes:

- the first line of 3rd paragraph to include the full name of Alison Delamare and Martin Rowell
- the first line of 3rd paragraph to read not standing for re-election instead of leaving the membership
- on p.4 living instead of leaving
- on p.5 add word if between and & that
- 6. 2nd paragraph 2nd line reads living, instead of leaving

Vida Djelic to correct the previous minutes. **VD**

4	**Matters Arising**	**CB**

1/Nov/09 welcome and Apologies **VD**

VD confirmed that thank you letter was sent to Martin Rowel and Alison Delamare on behalf of Chris Birch, Acting Chairman.

2/Nov/09 Minutes of previous meeting **VD**

VD said that she had made changes to the previous minutes as agreed at the last meeting.

3/Nov/09 Matters Arising **VD**

VD said that Matters Arising document presented at the last meeting in November was renumbered to make it clear which items from the minutes it refers to.

4/Nov/09 Communication methods with members **SN**

SN said that Capita confirmed that two such exercises had been completed. One exercise (Kings College Hospital) outcome unknown, Ashford & St Peters had 70% response.

CM asked what the next step would be. SN suggested that MA would include a flyer in the Trust News mail out which would have a minimal cost.

MA said that access to the newsletter will be done via the website as there is not an electronic version of the Trust News to be sent in an e-mail. He suggested that members should be consulted as to whether they prefer an e-mail of a hard copy version.

JS expressed his concern over the cost relating to postage. MA said that for 14,000 members it would cost approx £6,000.

WMW agreed with MA's views and stressed the importance of members being given the choice.

MA suggested that SN get information from Capita about Ashford and St. Peters Trust. **SN to obtain information.** **SN**

JB asked about a number of mailings that were returned when the Trust last time circulated its News.

MA said that initially there was a problem as it is very difficult to keep members details up to date constantly and that the problem was resolved later as the Trust asked members in its Newsletter to update their contact details.

SN said that 4.1 item under Matters Arising is on the agenda and will be discussed later in the meeting.

4.2 Welcome pack letter
SN said that she received comments from the sub-committee on the draft welcome pack letter which was tabled at the last sub-committee meeting on 10 November 2009.

CM suggested that SN prepare a revised draft welcome pack letter and circulate to the sub-committee for comments **SN**

SN said that she would get it done within two weeks.

CB asked how far SN has got with Young Persons' Membership. SN said that not much progress has been made as yet.

CB asked VD to ensure that this item get on the agenda at a future meeting. **VD**

5 Membership Work Plan **SN**

SN said that work plan for 2009/10 was completed and invited the sub-committee to evaluate the work plan.

SN added that the work plan for 2010/11 needs to be created and invited the sub-committee to put forward ideas.

CB said that most of our agendas contained 13 or 14 items and suggested that one meeting should be devoted entirely to discussing membership development and in particular membership engagement. He also suggested that Colin Glass should be invited to this meeting.
SN to invite Colin Glass to the Membership sub-committee meeting at which they would discuss membership development and membership engagement. **SN**

6 Membership Leaflet – final review **SN**

SN explained to the sub-committee that she had received a few comments on pervious version of the membership leaflet from the sub-committee.

CB suggested that the phone number should be added to the panel with the pictures of Heather and the Chairman.

CM suggested that the paragraph which reads 'if you are an employee' gets moved to the top of the Membership reply form section.

SN said that there is an amendment to the leaflet which reads: I consider myself to have a disability and I consider myself to have a learning disability.

GV suggested that OBE title should appear under Heather's name.

VD suggested that in the section referring to what the role of the Council of Governors is, the third paragraph gets moved to the top.

SN to make changes to the membership leaflet in line with the comments raised above and ensure that the electronic version is the **SN**

same as the hard copy.

Matthew Whiting joined the sub-committee meeting.

CB asked SN about the deadline for finalising the leaflet.

SN said that the Membership Leaflet should be completed within a week's time.

MA said that the leaflet should be ready for the Council of Governors meeting on 3 February.

WMW said that she had some feedback that people find it difficult to complete an on-line membership application form.

MA said that there is some work to be done on the membership application form available electronically and that SN via Capita will ensure that a hard copy is the same as the electronic version.
SN to follow up with Capita. **SN**

AMC joined the sub-committee meeting.

7 Learning Disability Membership Application Form

SN said that C&W Hospital Foundation Trust is establishing support services for people with a learning disability and proposed a different version of the membership form.

CB felt that all leaflets and forms should be easy to read and understand and he found it difficult to understand how they could be made even easier for people with learning difficulties.

SN said that there is an agency which makes leaflet with pictures and symbols and she was asking the committee to support a funding request.

CB asked for clarification on the Trust board being mentioned in the paper. It was confirmed that the word Board should be taken out.
SN to update the paper. **SN**

CB asked about a learning disability membership category.

SN explained that the Trust needs to know the number of those people with a learning disability so that they can get the appropriate level of support.

CB suggested that before the sub-committee commit to financially support this membership leaflet, SN should circulate the leaflet to the sub-committee to review. **SN to get a draft leaflet to the membership sub-committee.** **SN**

AMC suggested that SN obtain a sample copy of leaflet from another organisation. **SN to obtain.** **SN**

CM suggested that the creation of a new membership category to be removed from the paper as this would require a constitution change and should perhaps be addressed as part of any proposal for other constitution changes.

CM said that Heather Lawrence, Chief Executive, had suggested a contact at St. Georges for advice on learning disabilities. AMC confirmed he was

aware.

CB asked about the deadline for completion. AMC said that it should be done fairly soon. SN said that she would send a mock up leaflet to CB if possible.

It was agreed that this paper should go to the Council of Governors as part of the funding report and include a mock up if possible. **SN**

8 Community Mobile Health Clinic **SN**

SN said that those who attended the strategy meeting will be familiar with this proposal which had been presented there. The Mobile Health Clinic will offer health care services in the community and that the first health screening service will be offered at Chelsea Football Club (CFC), providing a 'well persons' clinic.

SN said that a few colleagues and herself had a sponsorship from a pharmaceutical company for purchasing a vehicle and establishing a mobile health clinic.

SN estimated that we will get 40 patients per session and for this there will be one receptionist, two nurses, security and cleaning staff. Funding is being provided by the PCT.

JB suggested that the mobile health clinic could be taken to the Duathlon at Richmond Park. SN confirmed that it could be taken there and other places as so flexible. The initiative at CFC is a pilot.

SN informed the sub-committee that she is currently working on promoting the mobile health clinic in conjunction with MA and WMW has also been a great help.

WMW said that John Hollins, and his son, Chris Hollins, will be helping us launch it on the day. WMW said that John Hollins was a patient of the C&W Hospital and that that will be acknowledged in the campaign for promoting the mobile health clinic. She added that it would also be interesting if John Hollins would give away some photos with his signature on it during the promotion. SN said that there will be good media coverage.

JB asked about the likely date of launch. SN said that the plan is to launch the community mobile health clinic on 7 February 2010.

SN clarified that she was asking this group to support a request to the Council of Governors for funding for the membership element of the project. This would then be put forward to the Council of Governors for approval.

CB invited any comments on the funding proposal.

The sub-committee confirmed that they approved funding of £3,444 (excl.VAT) for the Campaign Company to provide service in order to target potential Foundation Trust members on the clinic dates.

9 Development of the Trust Website - presentation **MA**

MA gave an overview of the development of the Trust Website which was supported by the Council of Governors.

MA said that he has established the Website Development Steering Group on which we have two member representatives from the Council of

Governors.

GV gave a presentation on the progress of the development between March 2008 and March 2009. The main points included:

- The number of visitors to our website is increasing consistently by roughly 600 users per month.
- The redesign of the website has given it direction and focus, and made it more visually appealing to visitors (more patient-centric).
- Use of large/bold photographs allows patients/visitors to better relate to the human element of healthcare.
- Simplified, friendlier text used (jargon avoided where possible, etc)
- Text made more concise to keep it shorter on pages where possible.

MA said that a big improvement was done on the HIV section of the website so that patients can request an appointment on-line and have access to services 24 hours. This helped us improve our services and reduce the cost.

CB invited sub-committee to put forward any comments.

CB concluded that it is very important to complete the Council of Governors section of the website where all of patient governors pictures would appear. GV confirmed that he and MA were working with those governors whose pictures are missing to get them done just before the Council of Governors meeting on 3 February.

10 Patient Information Screens **MA**

MA informed the sub-committee that the Trust has a contract with the Healthcare Messaging Group which specialises in providing sponsored digital healthcare messaging to NHS hospitals.

MA added that it was agreed that there will be 3 screens on the ground floor of the hospital – Paediatric Outpatients, Antenatal Outpatients and next to the M-PALS office. He pointed out that this is a pilot scheme which, if successful, will be rolled out across the Trust with more screens.

MA said that the aim is to provide high quality and up-to-date information to patients. By providing information electronically on the screens will reduce the current reliance on leaflets, flyers and other hard copy information which can become messy and out-of-date very quickly.

JB asked about sponsors for this project.

MA responded that the Trust will generate revenue through the sponsorship profit share with The Healthcare Messaging Group. He added that there is no financial risk to the Trust from the project and there is potential for a steady revenue stream, especially if over time the number of screens is increased.

MA said that the three screens are due to go live in two weeks time.

JB asked about screens that will appear and who would chose these screens.

MA said that they have been created by the company and approved by the Chief Executive. He also said that the screens will be refreshed regularly.

MA invited the sub-committee to give their feedback on the screens that will go live and also to suggest messages to be included on the screen in future.

JB suggested at that at some stage it would be useful to have a screen in the A& E department. MA agreed that this was a good idea and could be considered for the future.

11 Membership Mailing – April **MA**

MA informed the sub-committee that the Trust will be sending a membership newsletter to all members in April. MA said that it was proposed that a list of issues raised during the Q&A session at the Annual Members' Meeting in September 2009 could be used to help inform the contents of this newsletter by highlighting issues of concern/interest to members. MA invited the sub-committee to consider the list of issues circulated with the meeting papers and suggest possible articles for inclusion in the membership newsletter.

The sub-committee proposed the following items for inclusion in the newsletter:

- Work on the New Children Unit
- Hospital lifts
- Parking facilities, congestion charges, use of disabled parking.

JS highlighted his concerns about disabled people coming in. He did not feel that there was enough parking in the car park or in the surrounding environment. He would like Kensington and Chelsea to provide more disabled parking spaces. He emphasised that with the new paediatric wing there will be more people who will need help. GV also highlighted people parking in disabled spaces without a badge.

12 Council of Governors Election 2010 **CM**

CM informed the sub-committee that the Trust will have to hold an election for 3 seats coming up in May 2010 and also to fill in seats that were not filled in the last election held in October 2009.

CM noted that there had been some comments at the Council on governors for the boroughs and asked for some further discussion.

CM said that some of these posts are hard to fill and one option is to propose changes to the constitution, as part of a general review of the constitution. Alternatively, with fewer vacant sets to deal with, there is more opportunity to focus on improving nominations.

SSG suggested two representatives per borough rather than stipulating which areas. CB said he had mixed feelings as some of the boroughs were large and we might need representatives from the relevant areas. On the other hand the geographical location may not be that important. The committee felt that the category was important when standing for election but then not necessarily after the person was on the Council.

CM thanked the group for their comments. She emphasised that she did not want a decision at this stage but some idea of views.

13 Any Other Business

MA informed the sub-committee that the Trust will hold the Open Day on 8 May 2010 and that he would like to involve governors in organising the event. He invited members of the sub-committee to join the Open Day Steering Group meeting which will be held in the forthcoming week.
To notify MA if able to join the Steering Group. **All**

14 Date of next meeting

CB read out dates proposed for the future meetings of the sub-committee. These were as follows:

- Tuesday, 23 March
- Thursday, 13 May
- Thursday, 8 July
- Thursday, 2 September
- Thursday, 11 November

JB shared what she had learnt re mixed wards from a meeting about Imperial Healthcare and that it seemed there was a lot to do. She asked about our position. AMC outlined the arrangements at Chelsea and Westminster.

CB said that 23 March was the date of a Foundation Trust Governors Association development day, which it was useful for governors to attend. But, if an alternative date that suited CM, AMC and SN could not be found, we should go ahead with 23 March. **VD to find an alternative date, if possible.** **VD**

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 3 February 2010

AGENDA ITEM NO.	2.5.2/Feb/10
PAPER	Council of Governors Membership Report
AUTHOR	Sian Nelson, Membership and Engagement Manager
LEAD	Andrew MacCallum, Director of Nursing
SUMMARY	This paper provides the membership report for all member constituencies.
DECISION/ ACTION	For information.

Council of Governors Membership Report

1. Introduction

This paper sets out the present membership of Chelsea and Westminster Hospital Foundation Trust.

2. Member Constituencies

There are three Member Constituencies, Patient, Public and Staff. Membership for each constituency is illustrated in Table 1. The information in this report was updated on 26 January 2010.

Constituency	Members	Affiliate members	Total	Percentage
Staff	3,045	0	3,045	20
Patient	5,999	1	6,000	39
Public	6,128	242	6,370	41
Total	**15,172**	**243**	**15,415**	

Table 1: Membership

Monitor currently require different levels of analysis for each constituency and this is reflected in the report.

2.1 Patient Constituency

Patient members for 2009/10 is currently at 5,999. The Trust aims for growth of 5% in 2009/10, hence a further 356 new patient members will be required to achieve our target. The number of patient members who have left currently stands 425 (2009/10). The reasons for members leaving is generally either because of movement of address outside of the eligible constituency, or death.

Analysis of current patient membership requires us to report only on age. These figures are reflected in Table 2 below.

Age (years)	
0-16	0
17-21	64
22+	3,078
Unknown	2,857

Table 2: Patient membership by age range

2.2 Public Constituency

The Trust's target is to maintain the size of membership in the public constituency in 2010/11. Currently we have 6,128 public members and therefore we aim to recruit a further 244 members by March 2010. To date there have been 174 new members this year compared to 195 for 2008/09.

Ethnicity in this constituency demonstrates the highest proportion of membership within the Caucasian category and gender distribution remains higher in females than males. Analysis of the public constituency is represented in Table 3.

Ethnicity:	
White	4,364
Mixed	247
Asian	338
Black	288
Other	298
Socio-economic groupings	
ABC1	5,296
C2	4
D	0
E	812
Gender analysis	
Male	2,434
Female	3,652

Table 3: Analysis of Public membership

2.3 Staff Constituency

Staff membership has been updated to include all staff (deducting those who opt out, 15 staff). Table 4 shows staff members numbers were 487 as of the start of 1 April 2009. However, these were staff who applied to become members before the 'opt out' system was in place. The Human Resources department has reviewed all staff data, and the current staff membership is up to date as of 27 January 2010.

Staff constituency	
As at start April 1st 2009	487 (prior to 'opt-out' system)
New Members	2,559
Members leaving	1
At 27 January 2010	3,045

Table 4: Staff Constituency

All staff have been sent new membership cards by Capita, the membership database company. This has been an opportunity to discuss the positive aspects of membership and re-instate the importance of membership to the Trust.

3. Annual Work Plan

The Membership Development Annual Plan 2009/10 will be evaluated and a new work plan for 2010/11 is to be developed.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 3 February 2010

AGENDA ITEM NO.	2.6/Feb/10
PAPER	Draft minutes of the meeting of the Council of Governance Quality Sub-Committee held on 20 January 2010
AUTHOR	Vida Djelic, Interim FT Secretary
LEAD	Cathy Mooney, Director of Governance and Corporate Affairs
SUMMARY	This is a draft of proceedings at the meeting held on 20 January 2010
DECISION/ ACTION	The meeting is asked to note the draft minutes.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Quality Sub-Committee meeting, 20 January 2010

Draft Minutes

Attendees	Chris Birch	CB	Patient Governor
	Carol Dale	CD	Staff – Staff Governor
	Susan Maxwell	SM	Patient Governor
	Wendie McWatters	WMW	Patient Governor
	Sandra Smith Gordon	SSG	Public Governor – Kensington & Chelsea 2
In attendance	Mike Anderson	MA	Medical Director
	Andrew MacCallum	AMC	Director of Nursing
	Catherine Mooney	CM	Director of Governance and Corporate Affairs
	Vida Djelic	VD	Interim FT Secretary

1 Welcome and Apologies

Apologies were received from Rosie Glazebrook, Martin Lewis, Cyril Nemeth, Mary Symons and Jim Smith.

2. Terms of Reference

These were attached for information.

3. Recap of quality objectives and progress for this year **MA**

MA gave an outline of the current quality objectives. These were agreed at very short notice and therefore there was not much time to consult members, although they were discussed at the Council of Governors.

MA gave a presentation to the sub-committee on the quality objectives.

MA said that Lord Darzi identified three elements to quality: safety, clinical effectiveness and patient experience.

MA outlined the safety objectives to reduce our preventable venous thromboembolism (VTE) rate by 15% in the next year. He added that another objective was to reduce in-hospital cardiac arrest and mortality through earlier recognition and treatment of the deteriorating patient. The third objective was to reduce harm from certain high risk medicines (i.e. warfarin and opiates).

MA described the objectives relating to clinical effectiveness. He said that the first objective is to reduce delays of more than 24 hours to

selected non-elective urgent surgery. In addition, he explained that the national drive is to Reduce Hospital Standardised Mortality Ratio (HSMR) and we have set a target of 10%. The final objective was related to the time that urinary catheters are in place.

4. Monitor/DH consultation on Quality Accounts - other data/information which may be required – for information **CM**

CM explained to the sub-committee that the Quality Accounts will be required as part of legislation from April 2010 and that the stakeholder involvement is very important.
Monitor was consulting on the content of the Quality Account.

CM outlined the areas that were included in the consultation documents, so that the group was aware of possible future requirements
These include:

a) A statement from the Board demonstrating accountability for the content of the Quality Accounts.

b) Priorities for improvement and progress from last year. We chose the following 3 priority areas for quality improvement:

- VTE
- maternity experience
- surgery waiting times

c) An explanation of how a review of services was conducted.

d) Participation in clinical audits

e) A section on research.

f) A statement on the use of the Commissioning for Quality and Innovation payment framework.

g) A section on what patients say about the hospital.

h) A statement on data quality.

CM stressed that the involvement from stakeholders is key including patient experience. It is very important that governors get involved and ensure we get the priorities right, put initiatives in place, advise on implementing and communicate well so that it is understandable by public audience.

CM invited the sub-committee to comment.

SSG said she thought that the objectives were very arbitrary. MA said we choose those which involve the whole hospital and which we could do something about. WMW asked if we chose areas where we were weak. CM replied that one of the issues was the data available, and so we did not necessarily know. An example was the objective for warfarin. Once the data was checked it showed we were using it safely, so we may choose a different drug next time.

AMC said that at the last Annual Members' Meeting there were some questions about hospital appointments so clearly this is an area of concern that we are addressing.

MA said that we had a list of potential initiatives and measures. CB asked if there was a cost benefit analysis which would help identify which objective to choose. CM replied there was not, but some analysis would be helpful. The sub-committee asked if they could receive this list. **To circulate list of current ideas.** **CM**

SM asked about the problems with appointments and the need for more staff. MA felt that it was due to administrative inefficiencies and patients not being seen quickly enough. He also said that generally the perception of what is reasonable time has changed over the period of time. The waiting time requirement is for a patient to be seen within13 weeks. C&W wants to bring it to 6 weeks.

WMW asked about the definition of a patient experience. She also noted that people find it difficult to complain.

SSG said that there was a concern that hospital gowns were not of appropriate size. MA said that that if this was the case we should just buy bigger gowns for patients.

SM asked governors at the meeting about their hospital experience.

CB said we do not need a definition, but that it might be useful to get a break down of all of aspects of patient experience from coming to the hospital to discharge.

CD agreed that the discharge is very important point to be considered. She said that the time waiting for drugs prescription on the discharge is of concern.

The sub-committee discussed various aspects of patient experience and agreed that it is very important to capture experience from patients on both occasions when they are positive and happy with the care received and when they have not received a satisfactory care or when things go wrong. AMC said that we now record and track actions taken in response to complaints to ensure that changes are made.

MA said that we need to put down some ideas and to circulate them to the sub-committee to prioritise.

SSG suggested that we circulate the patient survey to all of the C&W members.

CD then suggested that we bring together a group of members with experience and get their ideas on how we improve.

MA added that we could inform the sub-committee about what other organisations/NHS Foundation Trusts are choosing as their objectives.

AMC said he will look at complaints received from patients in each area and suggest improvements in these areas.

CD highlighted two approaches she had heard of, 'experts by experience' e.g. using patients for a service review, and 'experienced based design'. A suggestion is that each governor finds five people with experience and talks to them.
Actions:
CM to circulate some ideas to the sub-committee and invite **CM**

feedback.
CM to circulate an extract from the previous Annual Report. **CM**
CM to note what other trusts are doing. **CM**

5. Quality Accounts – how to present progress (productive ward messages) and communication **MA**

CM said that one thing they had learnt from the business planning sessions was that knowledge of the quality objectives was not extensive and that the objectives could be worded in a way that people understand a bit better. She also emphasised that the quality accounts would be public documents and it was important to present the information in a way that people understand. She asked for the governors help in doing this. She had meetings arranged with relevant staff to start the process and would involve the governors when a 'mock up' had been prepared. This was agreed.
CM to arrange input into mock up for this year's report. **CM**

6. Date of next meeting **MA**

Vida Djelic to arrange future meeting dates. **VD**

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 3 February 2010

AGENDA ITEM NO.	2.7/Feb/10
PAPER	Council of Governors Funding Report
AUTHOR	Part A – Vida Djelic, Interim FT Secretary Part B – Sian Nelson, Membership and Engagement Manager Part C – Sian Nelson, Membership and Engagement Manager
LEAD	Vida Djelic, Interim FT Secretary
SUMMARY	This paper provides an overview of the funds spent in 2009/10 from the Council of Governors budget and proposals for future funding for discussion and agreement.
DECISION/ ACTION	The Council of Governors is asked to discuss and agree proposals.

Council of Governors Funding Report

Part A

1.0 Background

The decision was made at the November 2008 Council of Governors meeting that a recurring budget of £100,000 per financial year was to be made available to the Council of Governors to spend at their discretion on relevant projects. This budget was made available as of the financial year (1 April 2009).

The recurring budget was adjusted in the following financial year (2009/10) for the effect of inflation which is estimated at £500 bringing the total budget available in 2009/10 to £100,500.

2.0 Update

At the last meeting of the Council of Governors it was agreed that £15,000 will be provided for funding for Open Day 2010.

The Council of Governors also agreed an additional charge of £115 for the computer items which relates to VAT, which were not originally factored in when the report was agreed by the members at its meeting on 17 September 2009.

3.0 Funding Overview

Of the £100,500 circa 82K has been spent. In addition to that circa £19K remains in the budget to be spent for the remainder of the financial year (March 2010).

4.0 Use of funds FY 09/10

Activity	Estimated Budget	Spent
Trust Open Day 2009	£15,000	£12,334
Recruitment Campaign for Open Day 2009	£2,574	£2,574
Recruitment Campaign for Annual Members' Meeting	£2,574	£2,574
Recruitment of new members via Campaign for pre-election	£5,930	£2,956
Discharge Leaflets	£8,200	£8,200
Directory of Adult’s services	£19,817	£19,817
Information Zone seating, screen & wing art	£16,085	£16,236
Information Zone Security Kiosk move	£305	£305
Information zone Sec frame to TV, Kiosk move contingency, Project management fees	£3,763	£3,763
Website development	£12,800	£12,800
Computer items which relates to VAT	£115	£115
Total:	**£87,163**	**£81,674**

5.0 Proposed Items for Future Funding

These are outlined below.

Part B

Learning Disability Membership Leaflet - Proposal

This paper outlines a proposal for the Learning Disability Membership Leaflet.

1.0 Introduction

Chelsea and Westminster Hospital Foundation Trust are establishing support services for people with a Learning Disability. This includes the provision of easy to read information sheets. The Care Quality Commission has published indicators that we must follow and these include the provision support and easy to read information for people with a learning disability. The Trust must ensure we provide evidence of support by April 2010.

2.0 Aims

It is our aim to ensure accessibility for all to become members of the Trust and ensure we represent a diverse population. A Foundation Trust Membership Application leaflet that is specially designed will create membership accessibility for people with a learning disability.

3.0 Implementation

Once funding is agreed, the membership forms will be adapted by a specialist agency and printed. Implementation date aim is April 2010.

4.0 Funding

The Membership sub-committee discussed the Learning Disability Membership Leaflet at their meeting on 26 January. The sub-committee it was agreed that this paper should go to the Council of Governors as part of the funding report and include a mock up if possible.

5.0 Actions for the Council of Governors

The Council of Governors are asked to support funding of £1, 304.00 to create a Learning Disability Foundation Trust Membership Application Leaflet.

Part C

Community Mobile Health Clinic – Membership Recruitment - Proposal

Please see item 2.3 for reference regarding membership recruitment.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 3 February 2010

AGENDA ITEM NO.	3.1/Feb /10
PAPER	Finance Report – December 2009
AUTHOR	Kelda Alleyne, Deputy Director of Finance
LEAD	Lorraine Bewes, Executive Director of Finance
EXECUTIVE SUMMARY	The reported financial position for the Trust as at 31st December 2009 is a surplus of £4.6m, which is £0.5m behind plan. However, Earnings before depreciation, tax and amortisation (EBITDA) are £2.7m behind plan. If it were not for a fortuitous reduction in depreciation, following from the correction of the building valuation to reflect 50% rather than nil residual value, the Trust would have been c£3m behind plan at M9. The pressures relate in part to the delivery of our elective surgical plan being behind, although this has been more than offset by significant non elective activity over performance; nurse pay budgets were overspent at the beginning of the year but the monthly average spend has reduced through a reduction in the use of agency in recent months; and non pay budgets in pathology and an unachieved procurement savings programme. Therefore a recovery plan for each directorate has been mandated with the aim of pulling back the EBITDA shortfall by £2.7m. During Q3, £1.2m has been achieved. The forecast for the year end is a net surplus of £6.9m which is a projected overachievement of £0.5m on the original £6.4m plan, but this is still behind the recovery plan target by £2.5m. Despite the variance from plan, the financial position at the 31st December and the forecast for the year is still a relatively strong financial performance delivery, equivalent to a Level 4 financial risk rating (excellent). Cash flow is broadly on plan and the full year forecast is for £1.9m below plan.
DECISION/ ACTION	The Council is asked to note the financial position for the period to 31st December 2009 and the updates in this report.

Financial Report to the Council of Governors of Chelsea & Westminster Hospital NHS Foundation Trust
31st December 2009

1.0 INTRODUCTION

This paper presents the financial position of the Trust for the first nine months of 2009-10 focusing on the key issues for income and expenditure, cash flow and balance sheet in the month, year to date and year end forecast.

2.0 OVERALL FINANCIAL POSITION

The year-to-date position is a surplus for the nine months to £4.62m with an EBITDA[1] of £7.5% and a financial risk rating of 4 (excellent). The Trust full year forecast is for a surplus of £6.92m at the end of the twelve month period. The quarterly analysis of the forecast surplus is illustrated in Table 1 below:

Table 1
Quarterly Analysis of Surplus / (Deficit)

	Quarter 1	Quarter 2	Quarter 3	Quarter 4 (forecast)	Total (forecast)
	£m	£m	£m	£m	£m
Income	77.41	75.26	76.66	78.83	308.17
Pay	(40.28)	(39.89)	(41.03)	(41.17)	(162.37)
Non-Pay	(30.16)	(30.86)	(29.98)	(30.95)	(121.94)
EBITDA	6.98	4.52	5.65	6.71	23.86
Non-Operational	(5.01)	(3.37)	(4.15)	(4.42)	(16.94)
Surplus / Deficit	1.97	1.15	1.51	2.29	6.92
EBITDA Ratio	9.0%	6.0%	7.4%	8.5%	7.7%

The year-to-date financial position is behind plan by £0.53m. A Recovery Plan was implemented at the start of Q3 to improve the EBITDA position by £2.796m. During Q3 £1.19m has been achieved. HIV/GUM is forecast to fully achieve the recovery plan target. The main areas for focus in Q4 are Surgery, Medicine and Private Patients.

The CIP[2] target to Month 9 is £7.7m and of this 83% or £6.37m has been delivered. The full year forecast is for achievement of 89%. Within this, procurement savings of approximately £0.5m are at risk.

3.0 INCOME

The year-to-date income recorded is £229.34m and the full-year forecast is £308.05m.

[1] Earnings before Interest, taxes, depreciation and amortisation
[2] Cost Improvement Programme

NHS Clinical Contract Income has performed well year-to-date and stands ahead of plan by £1.04m. Other Operating Income exceeded year-to-date plan by £1.77m.

The full year forecast is for strong performance in all areas of income with the exception of Chelsea Wing Private Patients Income which has been impacted by the effects of the ITU closure.

3.1 NHS Clinical Contract Income

Summary

The full year income forecast remains unchanged i.e. projected over-performance of £1.32m.

The NHS Clinical Contract Income position for the nine months to 31st December 2009 was a surplus of £0.28m. This is in addition to £0.76m reflecting the prior year income.

The position by point of delivery is summarised.

Activity Type	Currency	In Month Activity	In Month Activity Variance %	Surplus / (Deficit) £000s	YTD Activity Actual	YTD Activity variance %	YTD Surplus / (Deficit) December 2009 £000s
Elective	Spells	441	15%	195	4,139	-1.2%	143
Planned Same day	Spells	1,726	15%	160	16,136	-1.3%	-204
Regular days	Spells	711	21%	-46	5,244	-18.2%	-96
Non Elective	Spells	3,100	15%	-460	26,072	10.2%	250
Critical Care – Adult	Bed days	159	-32%	-111	2,036	-2.0%	-178
Critical Care – Burns	Bed days	54	497%	32	436	443.4%	674
Critical Care - NICU/SCBU	Cot days	935	-12%	-89	8,417	-11.2%	-549
A&E attendances	Attendances	8,690	2%	21	76,287	0.6%	46
Outpatients(incls procedures and virtual clinics)	Attendances	34,242	15%	533	329,133	2.0%	459
Excess Bed Days	Excess bed days	1,960	69%	201	3,271	30.8%	923
Other	Tests and Provisions, Critical care correction	79,132	-2%	-377	724,459	-0.5%	-1,186
Total for 2009/10		**131,151**		**59**	**1,206,261**	**0.6%**	**281**

3.2 Other Operating Income

Other Operating Income earned YTD was £39.09m.

Table 4 Other Operating Income						
	In Month			Year to date		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Other NHS non tariff	0.08	0.07	(0.01)	0.57	0.73	0.16
Private Patient Income	0.80	0.70	(0.11)	6.99	5.96	(1.03)
Other non-NHS Clinical revenue	0.09	0.07	(0.02)	0.76	1.04	0.28
Research & Development Income	0.34	0.40	0.06	3.07	3.33	0.26
Education & Training Income	2.04	2.03	(0.01)	18.12	18.52	0.40
Misc other operating income	0.87	1.06	0.19	7.81	9.52	1.71
Total Other Operating Income	4.22	4.33	0.11	37.32	39.09	1.78

With the exception of Private Patient Income, Other Operating Income performed well and exceeded plan by £1.78m year-to-date.

The full year forecast for Other Operating Income is £53.41m. This takes account of a marginal improvement in Private Patients Income growth against an easing of Salary Recharges and Other Miscellaneous Income in Quarter 4.

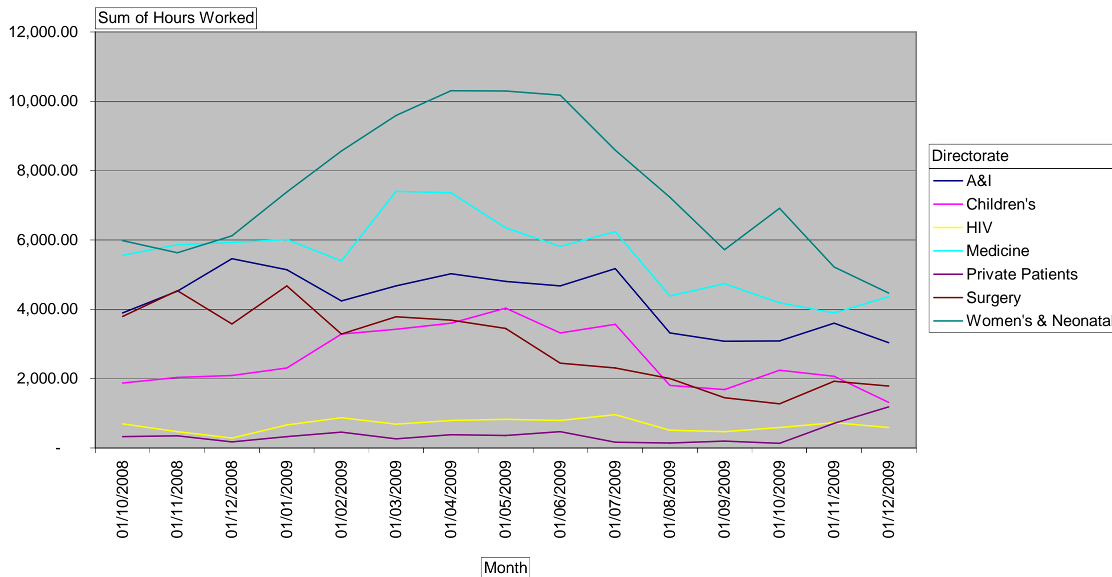
4.0 Expenditure (F2D)

4.1 Pay expenditure

4.1.1 A deficit of £1.00m is reported against expenditure budgets in December, reflecting an under spend of £0.07m against pay budgets and an over spend of £1.12m against non-pay budgets in month. YTD the net pay overspend (after salary recharges) is £1.20m (1% of budget) and the non pay overspend is £3.00m (3.4% of budget).

4.1.2 The Medical pay budget showed a positive variance of £0.02m in month and Medical locum expenditure was reduced compared to November at £0.13m in month.

4.1.3 Nursing Pay broke even against budget in month and Other Pay (AHPs and Admin staff) under spent by £0.05m. Within the nursing pay position this month, contracted pay and bank and agency nursing pay remained essentially in line with M8. The graph below shows the trend of nursing agency hours by Directorate over the period from October 2008-December 2009.



4.2 Non-Pay Expenditure

4.2.1 Costs incurred for clinical supplies year-to-date amounted to £24.97m and represents a significant overspend in relation to the plan. This trend of expenditure is expected to continue in Quarter 4.

4.2.2 Costs incurred for non-clinical supplies year-to-date amounted to £29.15m. This also represents a significant over-spend against plan due to unachieved procurement savings, catch up of costs, increased provisions for expenditure, relocating patients and conversion and deep-cleaning of wards.

4.2.3 The drug spend in relation to plan continues to improve with the recovery plan in place to control scripts of HIV drugs.

4.2.4 Spending on education and training has continued to remain below plan and it is expected that this trend will continue in Q4.

4.2.5 Research & Development expenses were behind plan due to write-off of 2008/09 deferred expenses in December 2009 as well as a reallocation of FSF to the directorates, which have been accounted for as a transfer of costs from other directorates to Research & Development directorate.

BALANCE SHEET

5.0 WORKING CAPITAL DAYS

The working capital days versus plan are set out in the table below.

	Dec 09	Mar 10	
	Current Month Actual	Forecast	Monitor Plan
Stock days	31	27	35
NHS Trade Debtor days	16	15	8
Non-NHS Trade Debtor days	6	9	21
Trade Creditor days	30	30	35
Liquid Ratio (days)	33	23	27
Return on Assets Employed	4.9%	5.6%	5.0%

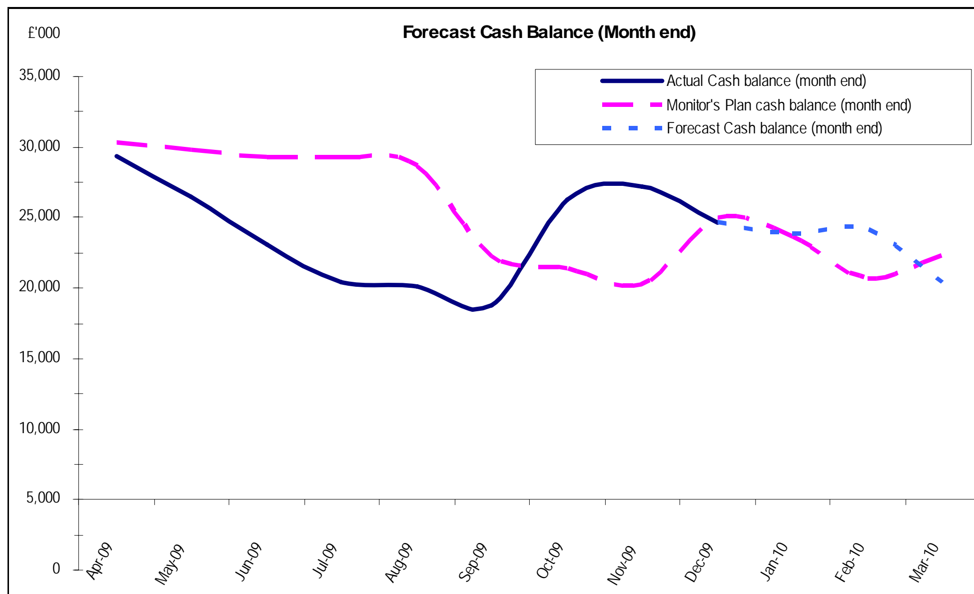
6.0 CASH FLOW

6.1 The cash position at the close of the month was £24.6m compared with the Monitor plan of £24.9m which is lower than plan by £0.3m.

Operating cash flows have been adversely affected by poor EBITDA performance. Early payments relating to the K&C SLA of £8.1m have been offset by an increase in HIV Out-of-London debtors and changes in assumptions around the timing of collections for contract over-performance and non-contract activity.

There has been an increase in cash due to delays in capital programme and the consequent deferral of the loan facility drawdown.

6.2 The graph below shows the actual/forecast cash balance for the financial year compared to the Monitor Plan:



6.3 The year end forecast cash balance is £1.9m lower than the Monitor plan due to the same underlying factors described in 6.1 above.

7.0 CAPITAL PROGRAMME

7.1 The Capital Budget for the year submitted to Monitor is £35.5m. The revised budget for the year at 31 December 2009 is £23.7m. The Trust has received £0.1m from St. Stephen's AIDS Research Trust to fund a mobile clinic in this month.

7.2 The budget of the Netherton Grove Build project as approved by the Trust Board stays the same at £36.5m. The majority of the expenditure will take place in2010/11 and 2011/12.

8.0 I&E Forecast

8.1 The forecast for the year end is a net surplus of £6.915m, which is £0.515m above the planned surplus of £6.4m. The key risks within the position are:

- The income forecast assumes delivery of the capacity plan over the remaining year and market share remains at current levels.

- Increased Pay costs to maintain high levels of activity.

- Research & Development Income being deferred to 2010/11 may have a net impact to the Trust in relation to CLARHC, Neonates projects. The existing results has accounted for the Income in line with the funding profile.

- Review of Non-Pay has highlighted that the practice of late invoices leads to 'surprise' accruals. A trend which was recognised at the end of 20098/09. This will have to be reviewed, but this may also pose a risk in 2009/10. The emphasis will be on ensuring that income, expenditure is recognised in the correct accounting period.

Lorraine Bewes
Director of Finance and Information
22nd January 2010

Glossary of Terms

CIP: Cost Improvement Programme

Clinical Contract Income: Income from Primary Care Trusts (PCTs) for activity carried out by the Trust under agreed contracts.

Point of Delivery: Type of care, eg inpatient, outpatient or daycase.

EBITDA: Earnings before Interest, Taxes, Depreciation and Amortisation.

Excess Bed Day Income: Income earned when patients stay in hospital longer than average for a particular procedure.

Elective: Planned Care (non emergency)

Non Elective: Emergency Care, e.g. ITU, Burns.

NICU: Neonatal Intensive Care Unit

SCBU: Special Care Baby Unit

Conversion Rate: The normal % of Outpatient or A&E attendances that become inpatient admissions.

Tariff: Nationally agreed price for a particular procedure.

PASA: NHS Purchasing and Supply Agency

Accrual: Accounting provision for liability where the goods or services have been received but the invoice has not yet been accounted for.

Acuity: Seriousness of a patient's condition

Locum: Temporary doctor covering vacancy or staff absence.

Working Capital: Assets available for use in the production of further assets, e.g. stock.

BPPC: Better Payment Practice Code

Deferred Income: Income received relating to a future period which is carried forward on the balance sheet.

IM&T: Information Management and Technology

Monitor: Regulatory body for NHS Foundation Trusts.

CHELSEA & WESTMINSTER HOSPITAL NHS FOUNDATION TRUST
FINANCE REPORTS
December 09

	FINANCE DIRECTOR'S REPORT	REPORTS TO	PAGE
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CHELSEA & WESTMINSTER HOSPITAL NHS FOUNDATION TRUST

CONSOLIDATED INCOME & EXPENDITURE SUMMARY

Responsibility: Finance Director

TRUST WIDE

FINAL - LEDGER CLOSED

FORM F1
December 09

FORM F1 December 09	THIS MONTH			YEAR TO DATE			FULL YEAR			
							MONITOR	FULL YEAR	FORECAST	
	BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE	PLAN	BUDGET	ACTUAL	VARIANCE
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
INCOME										
NHS Clinical Contract Income	(19,527)	(19,575)	48	(189,209)	(190,248)	1,040	(253,571)	(253,293)	(254,753)	1,460
Other NHS non tariff	(81)	(74)	(7)	(571)	(728)	158		(792)	(1,073)	280
Other non-NHS Clinical revenue	(85)	(66)	(19)	(763)	(1,039)	276	(993)	(1,017)	(1,444)	427
Private Patient Income	(802)	(695)	(107)	(6,988)	(5,957)	(1,031)	(9,236)	(9,472)	(8,369)	(1,102)
Education & Training Income	(2,044)	(2,031)	(13)	(18,118)	(18,521)	404	(22,778)	(24,110)	(24,605)	495
Research & Development Income	(340)	(401)	60	(3,069)	(3,330)	261	(4,041)	(4,090)	(4,516)	426
Misc other operating income	(867)	(1,059)	191	(7,806)	(9,517)	1,711	(17,247)	(11,497)	(13,405)	1,908
TOTAL INCOME	**(23,746)**	**(23,901)**	**155**	**(226,522)**	**(229,341)**	**2,818**	**(307,866)**	**(304,271)**	**(308,165)**	**3,894**
EXPENDITURE										
Medical Pay - Contracted	4,126	3,865	262	37,080	35,279	1,801		49,747	47,232	2,515
Medical Pay - Locum	12	132	(120)	108	2,474	(2,366)		144	3,248	(3,103)
Medical Pay - R&D	3	127	(124)	23	206	(183)		31	328	(297)
Sub-total Medical Pay	**4,141**	**4,123**	**18**	**37,211**	**37,959**	**(748)**	**0**	**49,922**	**50,807**	**(885)**
Nursing Pay - Contracted	5,111	4,071	1,040	45,600	35,384	10,216		60,895	47,554	13,341
Nursing Pay - Agency	70	619	(550)	779	7,753	(6,974)		818	9,827	(9,009)
Nursing Pay - Bank	11	496	(484)	107	4,777	(4,670)		361	6,367	(6,007)
Nursing Pay - R&D	2	8	(7)	16	54	(38)		22	154	(132)
Sub-total Nursing Pay	**5,194**	**5,194**	**(0)**	**46,502**	**47,968**	**(1,465)**	**0**	**62,095**	**63,902**	**(1,807)**
Other Pay - Contracted	3,755	3,248	507	33,339	28,264	5,074		46,670	38,914	7,757
Other Pay - Agency	5	104	(99)	204	2,870	(2,666)		208	3,425	(3,217)
Other Pay - Bank	6	302	(296)	61	2,865	(2,804)		81	3,600	(3,519)
Other Pay - R&D	157	221	(64)	1,404	1,271	133		1,874	1,723	151
Sub-total Other Pay	**3,923**	**3,876**	**48**	**35,008**	**35,271**	**(263)**	**0**	**48,833**	**47,662**	**1,172**
Sub-total Pay	**13,258**	**13,193**	**66**	**118,721**	**121,197**	**(2,476)**	**160,026**	**160,851**	**162,371**	**(1,520)**
Clinical supplies	2,461	2,953	(492)	23,080	24,966	(1,886)		30,770	33,374	(2,604)
Non-clinical supplies	3,173	3,731	(558)	28,601	29,147	(546)		38,725	39,843	(1,118)
Drug Costs - Tariff	2,920	2,820	100	28,236	29,069	(833)		37,090	37,518	(428)
Drug Costs - Exclusions	790	823	(33)	6,637	7,105	(468)		8,760	9,743	(984)
Education and training expense	72	53	19	647	357	290		864	565	299
Research & Development expense	50	207	(157)	731	350	381		970	894	76
Sub-Total Non Pay	**9,465**	**10,585**	**(1,120)**	**87,932**	**90,994**	**(3,062)**	**121,270**	**117,178**	**121,937**	**(4,759)**
TOTAL COSTS	**22,723**	**23,778**	**(1,055)**	**206,653**	**212,191**	**(5,538)**	**281,296**	**278,029**	**284,308**	**(6,279)**
EBITDA	**1,023**	**123**	**(900)**	**19,869**	**17,149**	**(2,720)**	**26,570**	**26,242**	**23,857**	**(2,385)**
EBITDA %	4.3%	0.5%		8.8%	7.5%		8.6%	8.6%	7.7%	61.3%
Depreciation	848	611	237	7,400	5,439	1,961	10,277	10,022	7,532	2,490
Interest Payable	70	52	18	511	491	20	741	742	648	93
Interest Receivable	(5)	(9)	4	(59)	(73)	14		(73)	(88)	14
PDC Dividend expense	763	727	36	6,864	6,540	324	9,152	9,152	8,719	433
Profit/Loss on Asset Disposal	0	0	0	0	131	(131)		0	131	(131)
SURPLUS / (DEFICIT)	**(653)**	**(1,258)**	**(606)**	**5,153**	**4,622**	**(531)**	**6,400**	**6,400**	**6,915**	**515**

CHELSEA & WESTMINSTER HOSPITAL NHS FOUNDATION TRUST

TRUST WIDE SUMMARY BY DIRECTORATE

Responsibility: Finance Director

FINAL - LEDGER CLOSED

FORM F3A
December 09

Directorate/ Service Area	Accountability	Rating	Annual Budget					In Month Variance					YTD Variance					Full Year Forecast at December 09				
			Income	Pay	n-Operatio	Non-Pay	Total	Income	Pay	h-Operatic	Non-Pay	Total	Income	Pay	on-Operation	Non-Pay	Total	Income	Pay	h-Operatic	Non-Pay	Total
Central Income			£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SaFF income	Lorraine Bewes		(253,293)	0	0	0	(253,293)	(170)	0	0	0	(170)	(492)	0	0	0	(492)	(570)				(570)
Central Non SaFF income	Lorraine Bewes		(23,865)	0	0	0	(23,865)	(47)	0	0	0	(47)	47	0	0	0	47	57				57
Total Central Income			(277,158)	0	0	0	(277,158)	(217)	0	0	0	(217)	(446)	0	0	0	(446)	(513)	0	0	0	(513)
Frontline Directorate																						
Imaging & Anaesthetics	Alan Kaye		(698)	25,820	0	6,203	31,324	1	23	0	(22)	2	605	(630)	0	(122)	(147)	634	(833)		(40)	(239)
HIV/GUM	Debbie Richards		(382)	12,896	0	39,030	51,544	237	(23)	0	125	340	1,185	(81)	0	(81)	1,023	1,407	(176)		(209)	1,022
Medicine & A&E	Melissa Coales		(925)	28,409	0	9,242	36,726	31	68	0	(152)	(53)	50	(446)	0	(589)	(986)	292	(404)		(725)	(837)
Surgery	Charles O'Hanlon		(423)	17,826	0	6,628	24,031	45	(56)	0	(224)	(235)	220	(385)	0	(1,098)	(1,263)	573	(304)		(1,445)	(1,176)
Children's Services	Debbie Richards		(296)	14,022	0	2,632	16,358	(82)	(50)	0	1	(130)	915	(667)	0	(70)	179	1,329	(859)		(161)	309
Women's Neonatal Services	Debbie Richards		(5,988)	28,883	0	4,334	27,229	192	(84)	0	(23)	85	250	(260)	0	(144)	(155)	79	53		(232)	(100)
Subtotal Frontline Directorates			(8,712)	127,856	0	68,068	187,212	425	(122)	0	(294)	8	3,225	(2,469)	0	(2,104)	(1,348)	4,202	(2,522)	0	(2,812)	(1,020)
Pharmacy	Karen Robertson		(956)	4,717	0	323	4,084	(28)	28	0	1	0	(29)	41	0	(13)	(1)	(42)	56		(13)	0
Physiotherapy & Dietetics	Douline Schoeman		(433)	5,680	0	154	5,401	6	(3)	0	3	6	45	32	0	(9)	68	42	88		(8)	121
Regional Pharmacy	Not applicable		0	0	0	0	0	0	(0)	0	(0)	(0)	0	4	0	(4)	(0)	0	0		0	0
Subtotal Clinical Support			(1,389)	10,398	0	476	9,485	(22)	25	0	4	6	15	76	0	(26)	66	(1)	143	0	(21)	121
Chief Executive	Heather Lawrence		0	1,401	0	153	1,554	0	27	0	1	28	10	275	0	(54)	232	10	273		(66)	218
Governance & Corporate Affairs	Cathy Mooney		0	875	0	5,198	6,074	0	15	0	11	26	1	50	0	123	173	1	49		42	92
Nursing	Andrew MacCallum		(98)	1,892	0	290	2,084	14	13	0	(55)	(27)	121	121	0	(199)	43	157	133		(232)	58
Human Resources	Mark Gammage		(121)	2,288	0	198	2,365	11	22	0	(3)	30	113	27	0	(87)	53	113	37		(87)	63
Finance	Lorraine Bewes		(191)	5,341	(73)	919	5,996	20	92	0	(49)	62	27	(5)	0	(107)	(85)	93	(4)		(79)	9
IC&T & EPR	Alex Geddes		0	2,534	0	2,554	5,088	0	29	0	(32)	(3)	1	(58)	0	36	(21)	1	(75)		46	(29)
Subtotal Management Exec			(410)	14,332	(73)	9,312	23,161	45	199	0	(128)	116	273	411	0	(289)	395	375	413	0	(376)	412
Facilities Management	Mark Lynn		(3,011)	547	0	22,585	20,120	(1)	3	0	(38)	(36)	(73)	34	0	954	914	(201)	5		785	589
Operation Management	Hannah Coffey		0	938	0	3	942	0	9	0	0	9	4	49	0	0	52	4	41		0	45
Research & Development	Derek Bell		(2,990)	1,927	0	970	(93)	55	(195)	0	(157)	(297)	322	(88)	0	381	615	506	(313)		76	269
Private Patients	Amanda Pritchard		(3,829)	1,045	0	484	(2,300)	(70)	(37)	0	36	(70)	(596)	(131)	0	64	(663)	(738)	(244)		182	(800)
Overseas	Amanda Pritchard		(961)	38	0	0	(922)	(44)	(1)	0	0	(44)	135	(7)	0	(6)	122	240	(10)		(6)	224
Post Graduate Centre	Kevin Shotlift		(3)	97	0	284	378	(0)	(10)	0	38	28	37	(44)	0	108	101	26	(47)		134	113
Projects	Hannah Coffey		(19)	1,187	0	86	1,255	1	18	0	(15)	4	4	106	0	(75)	35	4	99		(78)	24
Simulation Centre	Andrew MacCallum		(250)	498	0	68	316	(3)	6	0	(14)	(11)	76	53	0	(18)	110	98	47		(18)	127
Service Level Agreements	Hannah Coffey		(2,155)	(75)	0	14,547	12,317	41	(6)	0	(119)	(85)	114	(72)	0	(444)	(402)	154	(56)		(648)	(550)
Subtotal Other Directorates			(13,218)	6,203	0	39,028	32,013	(21)	(212)	0	(268)	(502)	22	(100)	0	964	885	92	(479)	0	427	40
Total All Directorates			(23,729)	158,788	(73)	116,884	251,871	427	(111)	0	(687)	(371)	3,535	(2,082)	0	(1,455)	(2)	4,668	(2,445)	0	(2,783)	(448)
Central Budgets																						
Capital Charges	Lorraine Bewes		(308)	0	18,866	308	18,866	(6)	0	267	6	267	(51)	0	2,234	48	2,232	(66)	(0)	2,923	(3)	2,854
Central Budgets	Lorraine Bewes		(3,076)	881	741	(628)	(2,082)	(49)	194	22	(527)	(360)	(220)	(70)	(96)	(2,339)	(2,726)	(272)	(70)	(23)	(2,258)	(2,623)
Reserves	Lorraine Bewes		(0)	2,652	0	(549)	2,103	0	(17)	0	93	75	(0)	(323)	0	736	412	(0)	2,431		(1,186)	1,245
Total Central Budgets			(3,384)	3,533	19,607	(870)	18,887	(55)	177	289	(428)	(17)	(271)	(393)	2,138	(1,555)	(82)	(338)	2,361	2,900	(3,447)	1,476
Net Deficit(-)/Surplus(+)			(304,271)	162,322	19,534	116,014	(6,400)	155	66	289	(1,115)	(605)	2,818	(2,475)	2,138	(3,011)	(530)	3,817	(84)	2,900	(6,230)	515

Chelsea & Westminster Hospital NHS Foundation Trust

BALANCE SHEET

Responsibility: Finance Director

FORM F6
December 09

	Mar 09	Nov 09	Dec 09	Mar 10	
	Opening Balance	Prior Month Actual	Current Month Actual	Forecast	Monitor Plan
	£'000	£'000	£'000	£'000	£'000
NON-CURRENT ASSETS					
Property	257,395	263,365	263,120	221,661	277,718
Plant & Equipment	26,589	25,658	25,291	24,653	30,295
Assets under construction	5,256	13,190	14,502	17,010	6,732
	289,240	302,213	302,913	263,324	314,746
CURRENT ASSETS					
Inventories	6,588	5,832	6,969	5,977	7,684
NHS Trade Receivables	6,565	11,724	11,651	11,213	5,971
Non NHS Trade Receivables	3,587	3,189	2,915	3,142	5,233
Provision for Impairment of Receivables	(2,574)	(2,752)	(2,752)	(2,446)	(2,690)
Other Receivables	3,069	3,118	2,993	3,149	2,510
Accrued income	312	38	397	487	559
Prepayments	458	2,024	1,475	976	761
Cash and Cash Equivalents	32,053	27,185	24,623	20,397	22,287
	50,058	50,358	48,272	42,895	42,313
CURRENT LIABILITIES					
Borrowings	(1,470)	(1,470)	(1,470)	(1,470)	(2,402)
Finance Leases	(47)	(159)	(160)	(163)	(164)
NHS Trade Creditors	(7,798)	(6,048)	(6,520)	(6,314)	(7,922)
Non NHS Trade Creditors - revenue	(3,187)	(5,124)	(4,916)	(4,929)	(4,356)
Other creditors	(7,250)	(6,161)	(6,178)	(6,328)	(7,501)
Capital Creditors	(1,076)	(756)	(1,336)	(5,628)	(2,728)
PDC Dividend creditor	-	(1,453)	(2,180)	-	-
Interest Payable Creditor	-	(83)	(124)	-	-
Accruals	(10,036)	(10,580)	(8,943)	(10,300)	(8,130)
Deferred income	(5,660)	(2,155)	(1,925)	(1,971)	(280)
Provisions	-	(1,852)	(1,852)	(1,778)	(22)
	(36,524)	(35,841)	(35,604)	(38,881)	(33,503)
Net Current Assets/(Liabilities)	13,534	14,517	12,668	4,014	8,810
Total Assets less Current Liabilities	302,774	316,730	315,581	267,338	323,555
NON-CURRENT LIABILITIES					
Borrowings: FTFF - £12.5m facility	(9,560)	(8,825)	(8,825)	(8,090)	(8,090)
Borrowings: FTFF - £27m facility	-	-	-	-	(12,069)
Finance Leases	(2,145)	(2,459)	(2,469)	(2,463)	(2,463)
Deferred income	-	(3,448)	(3,448)	(3,400)	(3,822)
Provisions	(440)	(466)	(466)	(463)	(390)
	(12,145)	(15,198)	(15,208)	(14,416)	(26,834)
Total Assets Employed	290,629	301,531	300,372	252,922	296,722
TAXPAYERS EQUITY					
Public Dividend Capital	162,549	162,549	162,549	162,549	162,549
Revaluation Reserve	91,320	91,320	91,320	43,135	91,320
Donated Asset Reserve	7,472	7,568	7,668	6,106	7,164
Retained Earnings	29,289	40,095	38,836	41,131	35,688
Total Taxpayers' Equity	290,629	301,531	300,372	252,922	296,722

Committed Working Capital Facility	20,000	20,000	20,000	20,000	20,000

KPIs

Stock days	33	26	31	27	35
NHS Trade Debtor days	7	15	16	15	8
Non-NHS Trade Debtor days	13	8	6	9	21
Trade Creditor days	31	29	30	30	35
Liquid Ratio (days)	53	37	33	23	27
Return on Assets Employed	6.4%	5.8%	4.9%	5.6%	5.0%

Chelsea and Westminster Hospital NHS Foundation Trust
CASH FLOW
Responsibility: Finance Director

	Apr 09			May 09			Jun 09			Jul 09			Aug 09		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Surplus/(Deficit) after Tax	630	(278)	(908)	630	614	(16)	630	1,630	1,000	706	661	(45)	706	575	(131)
non-cash flows in operating surplus/(deficit)	1,641	1,628	(13)	1,641	1,621	(20)	1,641	1,762	121	1,661	1,660	(1)	1,661	351	(1,309)
Operating Cash Flows before Movements in Working Capital	**2,271**	**1,350**	**(921)**	**2,271**	**2,235**	**(36)**	**2,271**	**3,392**	**1,121**	**2,366**	**2,321**	**(45)**	**2,366**	**926**	**(1,440)**
(Increase)/Decrease in Inventories	(639)	(752)	(113)	0	1,033	1,033	(657)	552	1,209	315	598	283	0	(408)	(408)
(Increase)/Decrease in Trade Receivables	(984)	(1,693)	(709)	(679)	(4,810)	(4,131)	(293)	(3,790)	(3,497)	(573)	(523)	50	(573)	(386)	187
(Increase)/Decrease in Other Receivables and Financial Assets	(445)	(347)	98	104	(1,266)	(1,370)	81	1,187	1,106	105	(421)	(526)	56	(499)	(555)
Increase/(Decrease) in Trade Creditors	1,609	1,505	(104)	216	(195)	(411)	134	(1,087)	(1,221)	123	(4,100)	(4,223)	119	721	602
Increase/(Decrease) in Other Creditors	734	(525)	(1,259)	23	(1)	(24)	4	(138)	(142)	140	110	(29)	0	(380)	(380)
Increase/(Decrease) in Other Financial Liabilities	(2,772)	(210)	2,562	0	901	901	0	(2,291)	(2,291)	(72)	803	875	0	1,055	1,055
Increase/(Decrease) in Provisions	(7)	22	29	0	0	0	(6)	67	73	0	(7)	(7)	0	3	3
Net Cash Inflow/(Outflow) from Operating Activities	**(231)**	**(650)**	**(419)**	**1,935**	**(2,103)**	**(4,038)**	**1,534**	**(2,108)**	**(3,642)**	**2,404**	**(1,220)**	**(3,624)**	**1,969**	**1,033**	**(935)**
INVESTING ACTIVITIES															
Property, Plant and Equipment - Expenditure	(2,050)	(1,903)	147	(2,050)	(913)	1,137	(2,050)	(1,115)	935	(2,551)	(1,666)	885	(2,551)	(936)	1,615
Increase/(Decrease) in Capital Creditors	531	(120)	(651)	(377)	107	484	0	(83)	(83)	301	322	21	0	(412)	(412)
Proceeds on Disposal of Property, Plant and Equipment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Purchase of Intangible Assets	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Government Grants Received	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Cash Inflow/(Outflow) from Investing Activities	**(1,519)**	**(2,023)**	**(504)**	**(2,427)**	**(806)**	**1,621**	**(2,050)**	**(1,198)**	**852**	**(2,250)**	**(1,344)**	**906**	**(2,551)**	**(1,348)**	**1,203**
Net Cash Inflow/(Outflow) before Financing	**(1,750)**	**(2,673)**	**(922)**	**(492)**	**(2,909)**	**(2,417)**	**(516)**	**(3,306)**	**(2,790)**	**154**	**(2,564)**	**(2,717)**	**(582)**	**(315)**	**268**
FINANCING ACTIVITIES															
Public Dividend Capital received	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Public Dividend Capital repaid	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC Dividends paid	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interest received on Cash and Cash Equivalents	11	15	4	0	28	28	0	9	9	0	9	9	0	5	5
Interest paid on Loans	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interest element of Finance Lease Rental Payments	(26)	(26)	0	0	0	0	0	(26)	(26)	(26)	0	26	0	0	0
Capital element of Finance Lease Rental Payments	(11)	(11)	0	0	0	0	0	(11)	(11)	(150)	(136)	14	0	0	0
Drawdown of Loans	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Repayment of Loans	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Cash Flows from Financing Activities	0	0	0	0	(3)	(3)	0	0	0	0	0	0	0	0	0
Net Cash Inflow/(Outflow) from Financing Activities	**(26)**	**(22)**	**4**	**0**	**25**	**25**	**0**	**(28)**	**(28)**	**(176)**	**(127)**	**49**	**0**	**5**	**5**
Net Increase/(Decrease) in Cash and Cash Equivalents	**(1,776)**	**(2,695)**	**(918)**	**(492)**	**(2,884)**	**(2,392)**	**(516)**	**(3,334)**	**(2,818)**	**(23)**	**(2,691)**	**(2,668)**	**(582)**	**(310)**	**273**
Opening Cash and Cash Equivalents	32,053	32,053	0	30,277	29,358	(918)	29,785	26,475	(3,310)	29,269	23,141	(6,128)	29,246	20,450	(8,796)
Closing Cash and Cash Equivalents	**30,277**	**29,358**	**(918)**	**29,785**	**26,475**	**(3,310)**	**29,269**	**23,141**	**(6,128)**	**29,246**	**20,450**	**(8,796)**	**28,664**	**20,141**	**(8,523)**

Chelsea and Westminster Hospital NHS Foundation
CASH FLOW
Responsibility: Finance Director

	Sep 09			Oct 09			Nov 09			Dec 09			Jan 10		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Surplus/(Deficit) after Tax	706	(90)	(796)	339	1,142	803	339	1,625	1,286	322	(1,258)	(1,579)	472	360	(111)
non-cash flows in operating surplus/(deficit)	1,661	1,358	(303)	1,683	1,385	(298)	1,683	1,380	(303)	1,701	1,381	(320)	1,726	1,497	(229)
Operating Cash Flows before Movements in Working Capital	**2,366**	**1,268**	**(1,098)**	**2,022**	**2,527**	**505**	**2,022**	**3,005**	**983**	**2,022**	**123**	**(1,899)**	**2,197**	**1,857**	**(340)**
(Increase)/Decrease in Inventories	(688)	162	850	1,095	(585)	(1,680)	0	155	155	(651)	(1,137)	(485)	770	439	(331)
(Increase)/Decrease in Trade Receivables	(65)	2,511	2,576	(618)	4,108	4,726	(488)	372	860	(2)	346	348	(453)	(1,080)	(627)
(Increase)/Decrease in Other Receivables and Financial Assets	44	(338)	(382)	(21)	1,488	1,509	19	(516)	(535)	16	406	391	14	(241)	(256)
Increase/(Decrease) in Trade Creditors	82	2,826	2,744	(145)	(791)	(646)	4	(533)	(537)	0	264	263	(129)	(758)	(628)
Increase/(Decrease) in Other Creditors	0	(197)	(197)	(172)	292	464	0	(250)	(250)	0	17	17	(97)	102	199
Increase/(Decrease) in Other Financial Liabilities	0	(885)	(885)	(429)	1,782	2,211	0	136	136	0	(1,959)	(1,959)	(191)	334	525
Increase/(Decrease) in Provisions	(6)	3	9	0	0	0	0	(23)	(23)	(6)	0	6	0	(3)	(3)
Net Cash Inflow/(Outflow) from Operating Activities	**1,734**	**5,350**	**3,616**	**1,733**	**8,821**	**7,088**	**1,558**	**2,346**	**788**	**1,380**	**(1,939)**	**(3,319)**	**2,111**	**649**	**(1,462)**
INVESTING ACTIVITIES															
Property, Plant and Equipment - Expenditure	(2,551)	(1,155)	1,396	(2,686)	(1,444)	1,242	(2,686)	(1,339)	1,347	(2,686)	(1,312)	1,374	(4,547)	(1,484)	3,063
Increase/(Decrease) in Capital Creditors	0	(208)	(208)	81	155	74	0	(100)	(100)	0	561	561	1,116	49	(1,067)
Proceeds on Disposal of Property, Plant and Equipment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Purchase of Intangible Assets	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Government Grants Received	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Cash Inflow/(Outflow) from Investing Activities	**(2,551)**	**(1,363)**	**1,188**	**(2,605)**	**(1,289)**	**1,316**	**(2,686)**	**(1,439)**	**1,247**	**(2,686)**	**(751)**	**1,935**	**(3,430)**	**(1,435)**	**1,996**
Net Cash Inflow/(Outflow) before Financing	**(817)**	**3,987**	**4,803**	**(872)**	**7,532**	**8,404**	**(1,128)**	**907**	**2,035**	**(1,307)**	**(2,691)**	**(1,384)**	**(1,320)**	**(786)**	**534**
FINANCING ACTIVITIES															
Public Dividend Capital received	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Public Dividend Capital repaid	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC Dividends paid	(4,576)	(4,360)	216	0	0	0	0	0	0	0	0	0	0	0	0
Interest received on Cash and Cash Equivalents	0	7	7	0	4	4	0	10	10	0	9	9	0	4	4
Interest paid on Loans	(270)	(270)	(0)	0	0	0	0	0	0	0	0	0	0	0	0
Interest element of Finance Lease Rental Payments	-	0	0	(25)	(25)	(0)	0	0	0	0	0	0	(25)	(25)	0
Capital element of Finance Lease Rental Payments	-	0	0	(12)	(12)	(0)	0	0	0	0	0	0	(12)	(12)	0
Drawdown of Loans	0	0	0	0	0	0	0	0	0	6,000	0	(6,000)	0	0	0
Repayment of Loans	(735)	(735)	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Cash Flows from Financing Activities	0	0	0	0	0	0	0	0	0	0	120	120	0	0	0
Net Cash Inflow/(Outflow) from Financing Activities	**(5,581)**	**(5,358)**	**222**	**(37)**	**(33)**	**4**	**0**	**10**	**10**	**6,000**	**129**	**(5,871)**	**(37)**	**(32)**	**4**
Net Increase/(Decrease) in Cash and Cash Equivalents	**(6,397)**	**(1,372)**	**5,026**	**(909)**	**7,499**	**8,408**	**(1,128)**	**917**	**2,045**	**4,693**	**(2,562)**	**(7,255)**	**(1,356)**	**(818)**	**538**
Opening Cash and Cash Equivalents	28,664	20,141	(8,523)	22,267	18,769	(3,497)	21,357	26,268	4,911	20,229	27,185	6,956	24,922	24,623	(299)
Closing Cash and Cash Equivalents	**22,267**	**18,769**	**(3,497)**	**21,357**	**26,268**	**4,911**	**20,229**	**27,185**	**6,956**	**24,922**	**24,623**	**(299)**	**23,566**	**23,805**	**239**

Chelsea and Westminster Hospital NHS Foundation
CASH FLOW
Responsibility: Finance Director

FORM F9A
December 09

	Feb 10			Mar 10			Year to Date			Full Year		
	Plan £'000	**Forecast** £'000	**Variance** £'000	**Plan** £'000	**Forecast** £'000	**Variance** £'000	**Plan** £'000	**Actual** £'000	**Variance** £'000	**Plan** £'000	**Forecast** £'000	**Variance** £'000
Surplus/(Deficit) after Tax	472	(365)	(837)	451	2,298	1,847	5,006	4,622	(384)	6,400	6,915	515
non-cash flows in operating surplus/(deficit)	1,726	1,449	(276)	1,746	1,468	(278)	14,972	12,526	(2,446)	20,170	16,941	(3,229)
Operating Cash Flows before Movements in Working Capita	**2,197**	**1,084**	**(1,113)**	**2,197**	**3,767**	**1,570**	**19,978**	**17,148**	**(2,830)**	**26,570**	**23,856**	**(2,714)**
(Increase)/Decrease in Inventories	0	192	192	(640)	361	1,002	(1,224)	(381)	844	(1,095)	611	1,706
(Increase)/Decrease in Trade Receivables	(537)	1,136	1,673	3,272	(149)	(3,421)	(4,275)	(3,865)	409	(1,992)	(3,959)	(1,967)
(Increase)/Decrease in Other Receivables and Financial Assets	12	89	77	10	314	304	(39)	(305)	(266)	(3)	(145)	(141)
Increase/(Decrease) in Trade Creditors	(25)	180	204	(19)	384	404	2,142	(1,391)	(3,534)	1,969	(1,584)	(3,554)
Increase/(Decrease) in Other Creditors	0	(5)	(5)	0	53	53	728	(1,072)	(1,801)	631	(922)	(1,554)
Increase/(Decrease) in Other Financial Liabilities	0	(82)	(82)	(0)	1,195	1,195	(3,272)	(667)	2,605	(3,463)	780	4,243
Increase/(Decrease) in Provisions	0	0	0	(6)	(74)	(68)	(24)	65	89	(29)	(12)	17
Net Cash Inflow/(Outflow) from Operating Activities	**1,647**	**2,593**	**945**	**4,814**	**5,851**	**1,037**	**14,015**	**9,531**	**(4,484)**	**22,587**	**18,624**	**(3,963)**
INVESTING ACTIVITIES												
Property, Plant and Equipment - Expenditure	(4,547)	(2,321)	2,226	(4,547)	(8,442)	(3,896)	(21,862)	(11,783)	10,079	(35,502)	(24,030)	11,472
Increase/(Decrease) in Capital Creditors	0	8	8	0	4,236	4,236	535	221	(314)	1,652	4,514	2,862
Proceeds on Disposal of Property, Plant and Equipment	0	0	0	0	0	0	0	0	0	0	0	0
Purchase of Intangible Assets	0	0	0	0	0	0	0	0	0	0	0	0
Government Grants Received	0	0	0	0	0	0	0	0	0	0	0	0
Net Cash Inflow/(Outflow) from Investing Activities	**(4,547)**	**(2,313)**	**2,234**	**(4,547)**	**(4,207)**	**340**	**(21,326)**	**(11,562)**	**9,765**	**(33,850)**	**(19,516)**	**14,334**
Net Cash Inflow/(Outflow) before Financing	**(2,899)**	**280**	**3,179**	**268**	**1,645**	**1,377**	**(7,311)**	**(2,030)**	**5,281**	**(11,263)**	**(892)**	**10,371**
FINANCING ACTIVITIES												
Public Dividend Capital received	0	0	0	0	0	0	0	0	0	0	0	0
Public Dividend Capital repaid	0	0	0	0	0	0	0	0	0	0	0	0
PDC Dividends paid	0	0	0	(4,576)	(4,359)	217	(4,576)	(4,360)	216	(9,152)	(8,719)	433
Interest received on Cash and Cash Equivalents	0	3	3	0	7	7	11	95	84	11	110	99
Interest paid on Loans	0	0	0	(338)	(248)	90	(270)	(270)	(0)	(608)	(518)	90
Interest element of Finance Lease Rental Payments	0	0	0	0	0	0	(77)	(77)	(0)	(101)	(102)	(0)
Capital element of Finance Lease Rental Payments	0	0	0	0	0	0	(173)	(170)	3	(185)	(182)	3
Drawdown of Loans	0	0	0	7,000	0	(7,000)	6,000	0	(6,000)	13,000	0	(13,000)
Repayment of Loans	0	0	0	(735)	(735)	0	(735)	(735)	0	(1,470)	(1,470)	0
Other Cash Flows from Financing Activities	0	0	0	0	0	0	0	117	117	0	117	117
Net Cash Inflow/(Outflow) from Financing Activities	**0**	**3**	**3**	**1,351**	**(5,334)**	**(6,685)**	**180**	**(5,400)**	**(5,580)**	**1,495**	**(10,763)**	**(12,258)**
Net Increase/(Decrease) in Cash and Cash Equivalents	**(2,899)**	**283**	**3,182**	**1,619**	**(3,690)**	**(5,309)**	**(7,131)**	**(7,430)**	**(299)**	**(9,768)**	**(11,655)**	**(1,887)**
Opening Cash and Cash Equivalents	23,566	23,805	239	20,666	24,088	3,421	32,053	32,053	0	32,053	32,053	0
Closing Cash and Cash Equivalents	**20,666**	**24,088**	**3,421**	**22,285**	**20,398**	**(1,887)**	**24,922**	**24,623**	**(299)**	**22,285**	**20,398**	**(1,887)**

CHELSEA & WESTMINSTER HOSPITAL NHS FOUNDATION TRUST

CAPITAL PROGRAMME REPORT 2009/2010

December 09

	CURRENT MONTH				YEAR TO DATE					FULL YEAR FORECAST				
SUMMARY	BUDGET	BUDGET DONATED	ACTUAL	VARIANCE	BUDGET	BUDGET DONATED	ACTUAL	VARIANCE	COMMITTED	BUDGET	BUDGET DONATED	SLIPPAGE	FORECAST	VARIANCE
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
A. BUILDINGS														
BACKLOG MAINT & LIFE EXPIRED	52	0	50	2	227	0	162	65	13	1,395	0	0	1,058	337
NEW BUILDING PROJECTS	36	0	37	(1)	661	0	782	(121)	1	2,471	0	0	2,565	(94)
MAINTENANCE/INFRASTRUCTURE	12	0	23	(11)	20	0	61	(41)	0	500	0	0	500	0
OTHER PROJECTS	0	0	0	0	0	0	0	0	0	1,000	0	0	1,000	0
NETHERTON GROVE EXTENSION	355	0	363	(8)	1,364	0	1,379	(15)	87	3,215	0	0	3,426	(211)
CARRIED FORWARD SCHEMES	138	0	293	(155)	3,856	0	4,914	(1,058)	191	5,538	0	(385)	6,180	(1,027)
SUB TOTAL FOR BUILDINGS	593	0	766	(173)	6,128	0	7,298	(1,170)	292	14,119	0	(385)	14,729	(995)
B. MEDICAL EQUIPMENT	409	0	356	53	1,224	35	1,301	(42)	879	3,526	35	0	3,381	180
C. NON MEDICAL EQUIPMENT	1	120	0	121	104	120	110	115	62	376	120	0	374	122
D. INFORMATION TECHNOLOGY	55	0	189	(134)	2,047	0	2,970	(923)	625	5,681	0	0	5,584	97
TOTAL CAPITAL PROGRAMME	**1,058**	**120**	**1,312**	**(134)**	**9,503**	**155**	**11,678**	**(2,020)**	**1,858**	**23,702**	**155**	**(385)**	**24,068**	**(596)**

Council of Governors Meeting, 3 February 2010

AGENDA ITEM NO.	3.2/Feb/10
PAPER	Performance Report for 9 months to 31 December 2009
AUTHOR	Amit Khutti – Director of Strategy & Planning
LEAD EXECUTIVE	Lorraine Bewes – Director of Finance and Information
SUMMARY	The purpose of this report is to update the Council on the Trust's service performance for the period ending 31st December 2009. Performance against the Monitor selection of indicators is broadly on track. However, performance against the MRSA target has deteriorated this year. Although there were no MRSA cases in December, the year to date total is 9 cases. At this level we are unlikely to achieve the stretch target A (carrying a bonus of £100,000) of 10 cases for the year, and we have already missed stretch target B of 5 cases (bonus of £150,000). We can however still achieve the stretch target B (£150,000) for Clostridium Difficile. The Trust is currently at a 'fully met' rating for existing and national targets for the Care Quality Commission. (CQC). There are some key risks that must be mitigated in order to achieve 'fully met' at the end of the year. These relate to the targets to have no inpatient waits above 26 weeks, cancelled operations not rebooked within 28 days, and delivery of the 18 weeks target. As long as performance against these targets does not worsen, we expect to receive an 'Excellent' rating. Next year we will be assessed against a new target for access to healthcare for people with a learning disability. A gap analysis has been undertaken and we are scored as partially compliant for all six indicators. A steering group has been convened to review the action plan. Another area of focus now for next year's performance is on the timeliness of discharge summaries where the target will move from completion within 48 hours of discharge to within 24 hours of discharge. We are currently sending 82% of discharge summaries within 24 hours of discharge and will need to improve this performance to 100% for next financial year as otherwise PCTs will have the option of withholding payments.
DECISION/ ACTION	The Council is asked to note the report.

PERFORMANCE REPORT FOR THE PERIOD December 2009

1. PURPOSE

1.1 The purpose of this report is to provide information about the Trust's performance for April to December 2009/10. The Council is asked to note the report and conclusions.

2. CONTENT OF PERFORMANCE REPORT

2.1. The attached performance report comprises of the following components:

- **Monitor Indicators**
- **Care Quality Commission Indicators**

3. SUMMARY OF PERFORMANCE REPORT

MONITOR

3.1 Performance remains stable in the third month of quarter 3.There were 0 cases of MRSA bacteraemia in December which brings the total for the 9 months YTD to 9. At this level, the Trust is still within its CQC/Monitor target but risks achievement of its stretch target (10) that would earn a £100k bonus. Of the 9 reported cases, 2 had community acquired bacteraemia and under current guidance may be offered in mitigation if the Trust exceeds its nationally set target of 19 cases.

3.2 The MRSA screening target measures the number of elective admissions we have in a month and the number of MRSA swabs we do. If the ratio for swabs against admissions is greater than 1 then the target is met. The MRSA screening ratio was 1.40 for December and 1.44 for the quarter.

3.3 The number of C Diff cases was below the target in December. There have been 29 cases so far this year against a maximum target of 73 in that time. We are below the threshold of 27.5 for quarter three with only 5 cases in quarter 3.

3.4 Monitor has confirmed that the target for the new 2 week wait for the urgent referral cancer standard is 93%. Our performance for the quarter is 95.95%.

3.5 The Department of Health announced details of the operational standards for existing and new commitments to cancer waiting times. A decision was taken by DH to align the monitoring of cancer waiting times with the existing 18 weeks data collection methodology, with the consequence that the previous thresholds required to assess performance against 31- and 62-day commitments are no longer valid. See the Care Quality Commission section for further details.

Implications for Monitor's regulatory framework are as follows:

- These targets come into effect with immediate effect and NHS foundation trusts have been required to declare and be scored against them from Q2;

- The two national requirements – the 62-day referral to treatment target and the 31-day wait for second or subsequent treatment target – include two thresholds. Failure of either or both thresholds will represent a single failure of the target, and this failure will be scored 1.0 under our service performance scoring framework

3.6 The new thresholds and our performance against them are highlighted in the table below. We are on track to meet this target under the Monitor framework.

Targets – weighted 1.0 (national requirements)	Threshold	Weighting	Q3 Performance
62-day wait for first treatment from urgent GP referral to treatment: all cancers	85%	1.0	92.03%
62-day wait for first treatment from consultant screening service referral: all cancers	90%	1.0	No referrals to date
31-day wait for second or subsequent treatment: surgery	94%	1.0	100%
31-day wait for second or subsequent treatment: anti cancer drug treatments	98%	1.0	100%
Targets – weighted 0.5			
31-day wait from diagnosis to first treatment: all cancers	96%	0.5	97.92%
Two week wait from referral to date first seen: all cancers	93%	0.5	95.95%

Table 1: New Cancer targets

3.7 Our A&E performance in December was 97.97% (98% target) and 98.30% for Quarter 3. See the Care Quality Commission section below for details.

3.8 18 week Trust level performance is detailed in section 4.

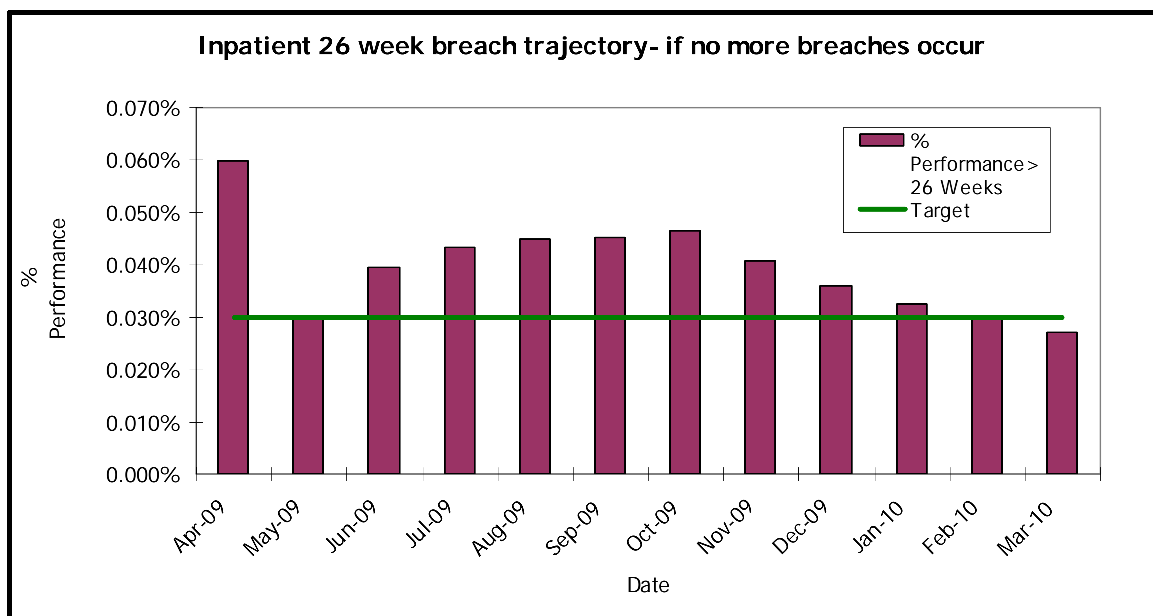
Care Quality Commission

The Care Quality Commission has published the first and second phases of the 2009/10 periodic review indicator constructions, which have now been formally approved. The remaining indicator constructions will be published as soon as they are approved.

Existing commitments indicators

3.9 We are on track to receive 'Fully Met' rating for the Existing Commitment indicator group as despite the Inpatient 26 week indicator falling below the target, we have met all other targets to date. However, there are a number of risks which are outlined below.

3.10 We have had no further breaches of the 26 week Inpatient target in December. The trust had 6 Inpatient breaches of the 26 week target in the year to date. This brings our performance to 0.037 against a target of 0.030%. The 6 breaches YTD relate to 3 patients; the first occurred in Pain management in April, the second was in General Surgery and counted four times and the last was in Ophthalmology.



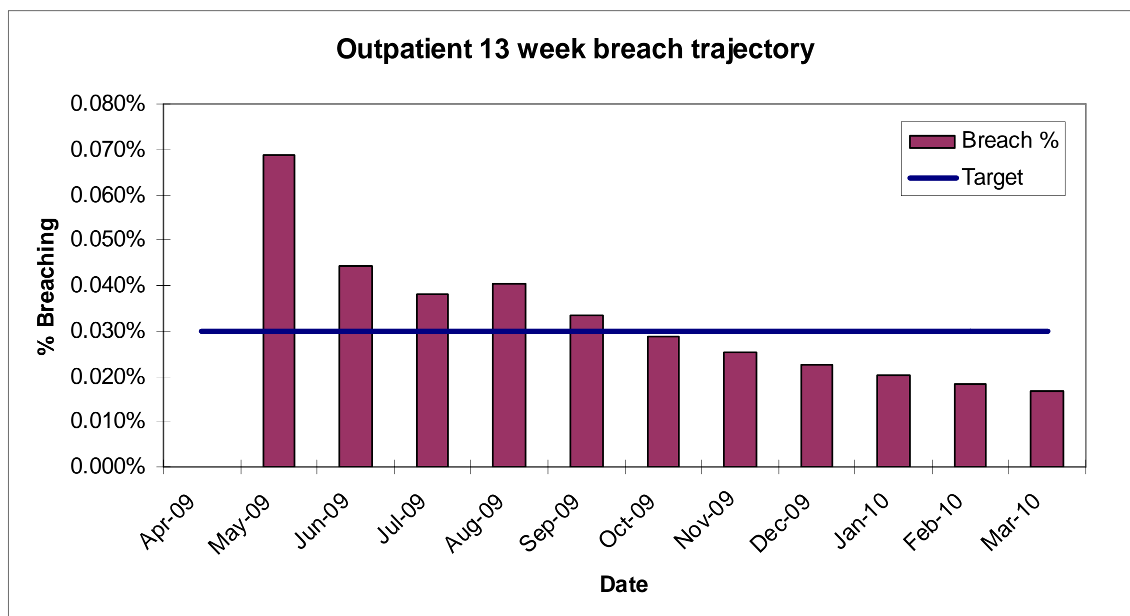
Graph 1. 26 week breach trajectory

3.11 Graph 1 above shows that if there are no more 26 week breaches, we can still achieve 'fully met' on this indicator. This also depends on activity remaining at least to current trend.

3.12 The Trust's performance for data quality for ethnicity year-to-date has dropped fractionally to 96.31% but remains comfortably above the target of 95%. .

3.13 We have had no further breaches of the 13 week outpatient wait standard in December. The total YTD breaches are 9. We are at 0.022% which is below the threshold of 0.03%.

3.14 Graph 2 below shows we are just below the threshold and can only tolerate up to 5 further breaches to still achieve the target, assuming activity remains on current trend.



Graph 2. 13 week breach trajectory

3.15 There were three 28 day cancelled operation breaches in General Surgery for December giving in month performance of 50% against a target of 95% and performance YTD has dropped to 94.06% against the target of 95%. This target measures instances in which we have cancelled a patient on or after the day of admission for non-clinical reasons and where we have not treated them within 28 days of cancellation. The General Surgery breaches were due to a lack of HDU capacity resulting from ITU being closed because of acitenobacter. Although we have now dropped below the target, if we have no more cancelled operations not rebooked within 28 days, we will meet the target. In addition, if the CQC uses last year's methodology, and we have less than 150 cancelled operations overall (year-to-date 108), the tolerance for breaches of the 'rebooking within 28 days' target should be doubled which would leave us having 'Achieved' the target.

3.16 The performance to date for cancelled operations by the hospital remains good for non-clinical reasons and is 0.44% (against a target of no more than 0.8%).

3.17 Our Performance for the Rapid Access Chest Pain Clinics in December has risen to 99.63%, compared with an expected threshold of 98%. This had dropped below 100% due to 1 patient breaching in November.

RACPC REFERRALS			
	Total number of patients	**% Complete**	**Patients seen within the target**
April	39	100.00%	39
May	28	100.00%	28
June	25	100.00%	25
July	25	100.00%	25
August	17	100.00%	17
September	19	100.00%	19
October	43	100.00%	43
November	47	97.87%	46

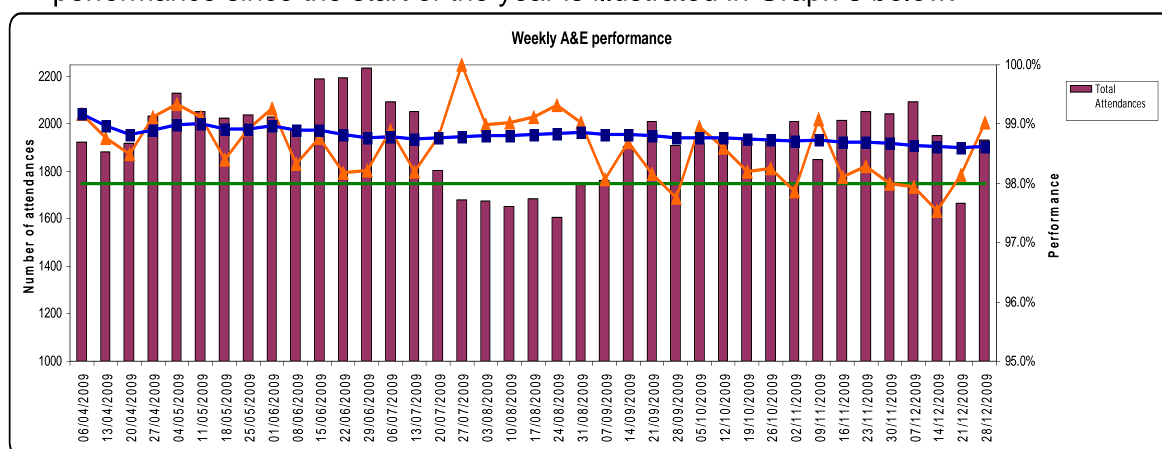
December	29	100.00%	29
Total	272	99.63%	271

***Table 2**. RAPC analysis*

3.18 The Trust's performance for Access to Genito-Urinary Medicine (GUM) clinics within 2 days year to date is 100%.

3.19 The delayed transfer of care data is not up to date due to the early reporting this month. As of the year to the end of November, the cumulative performance was 1.17% against an expected threshold of 3.5%. The number of delayed transfer patients has dropped significantly over the last calendar year from an average of five a week to an average of two.

3.20 Our performance for waiting times in A&E below a 4 hours wait is 98.52% for April to December. The number of A&E attendances is slightly lower compared to November. This has adversely affected performance in December which has fallen to 97.97%. Although we dipped slightly below target in December, this is against a backdrop of severe pressures across London during this month and a number of Trusts falling significantly below the target. Our Trust has performed well to maintain performance effectively at the 98% level. A&E activity and 4 hour wait performance since the start of the year is illustrated in Graph 3 below.



***Graph 3.** A&E activity and performance*

New National Priority indicators

3.21 For the new national priority targets (that we can track) we are on course to receive a "Fully Met" rating.

3.22 Our performance to date on data completeness for breastfeeding initiation to date is 89.28% (against a target of 95%) and data completeness for smoking during pregnancy to date is 99.26% (against a target of 95%). Failure to meet data completeness would mean the two standards below would not be assessed.

3.23 For the target to have fewer mothers smoking than last year, we are currently meeting the target as last year we had 4.81% of women smoking and this year (YTD) we have 4.28%.

3.24 4.2% more mothers are known to have initiated breastfeeding at delivery than last year. Performance is not allowed to worsen against last year by more than 5%.

3.25 The Maternity hospital episode indicator was updated at the end of November and gives additional clarification on the construction as set out in the extract below:

"HES data for the indicator will be sourced from Secondary Uses Service (SUS). Data transferred from SUS to HES will undergo cleaning and other processes. As a result, data submitted to SUS may differ from the data within HES.
We intend to use HES data relating to April to December 2009 which will be available from the month 9 provider submission deadline on 22 January 2010. The Care Quality Commission retains the right to use data from any provider submission deadline from 22 January 2010 and to assess all trusts using data from that provider submission deadline.
Data will be validated to ensure broad parity between the number of birth episodes and the number of babies recorded on delivery episodes. Trusts will be penalised where there is a significant disparity between the count of birth records and the count of births recorded on delivery episodes"

We are now able to judge performance using the number of births we have in the year so far and the number of birth episodes. As this data comes from SUS it is normally two months behind, however using the data we currently have we are performing at 97.99%. Last year the target was to have a data quality ratio of greater than 90% and less than 110%. We are currently well within this.

3.26 Access to healthcare for people with a learning disability is a new target. The Trust's position is not yet confirmed. A gap analysis has been undertaken and we are scored as partially met for all six indicators. A steering group has been convened to review the action plan. This indicator will not be included in the scored assessment for 2009/10. However, the Trust will be expected to collect the requisite information and report on it separately and the CQC will publish this along side the results of the review to ensure visibility.

3.27 The Stroke indicator has been simplified; there are now only two parts to the indicator. The first looks at the percentage of stroke patients who are treated in the stroke unit. The trust performance year to date for this indicator is 94.5% against a target of 70% as set in the Vital Sign's framework for PCTs. The second is the percentage of Transient ischaemic attack (TIA) cases with a higher risk of stroke that are treated within 24 hours The trust's year to date performance is 84.2% against an expected target of 45%. These targets are set by the Department of Health and are expected to rise each year to push up performance throughout the NHS.

3.28 Table 3 below shows the Trust's performance for all the different CQC cancer targets. The trust is currently meeting all targets.

Indicator Name	**YTD Performance**	**Performance Last Month**	**Target**
31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	**99.0%**	**96.7%**	**96.0%**
31-Day Wait For Second Or Subsequent Treatment: Surgery	**97.7%**	**100.0%**	**94.0%**
31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	**100.0%**	**100.0%**	**98.0%**

31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	**N/A**	**N/A**	**94.0%**
62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	**95.0%**	**90.9%**	**85.0%**
62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	**N/A**	**N/A**	**90.0%**
All Cancer Two Week Wait	**96.8%**	**94.7%**	**93.0%**

Table 3 CQC *Cancer targets summary*

4. 18 WEEK ACTIVITY

4.1. 18 week performance for December 2009

	Treated within 18 weeks		**Not treated within 18 weeks**		**Total volume**	**Unknown clock start date Volume**	**Data Completeness** (Threshold 90-110%)
	%	Volume	%	Volume			
Admitted	**94.92**	955	6.44	51	1143	2	**90.35**
Non-admitted	**99.37**	9499	1.26	120	11703	1	**90.06**

4.2. Predicted 18 week performance for January 2009

	Treated within 18 weeks		**Not treated within 18 weeks**		**Total volume**	**Unknown clock start date Volume**
	%	Volume	%	Volume		
Admitted	**85.76**	946	14.24	157	1103	

The quarter three position is positive for the Trust as we met the tolerance for breaches at specialty level. We did not meet the individual specialty level target for non-admitted Neurology over the quarter and in December itself. This does not adversely affect our ratings and we are still on course for being ‘fully met’.

For quarter four there is no tolerance at specialty level as all specialties must meet these standards. Current performance suggests January is going to be the most pressured month of the quarter and we are managing admissions to mitigate this pressure.

During December NHS London surveyed all London Trusts and national Health Authorities to assess the readiness for meeting the February deadline to submit data on SUS and for this patient level data to be used as part of the calculation for the Annual Health Check. This is to replace aggregated data sent directly to Unify.

The London picture;

- The majority of Acute Trusts are unlikely to be fully compliant by 1st Feb, and most are still completing a period of data cleansing and validation to reach a point where they are confidently sending all required data out in CDS extracts.

- PCTs are unable to submit CDS data to SUS at present, as a community CDS does not exist at present."

The DoH has responded

> *"The exact point at which we will switch over will depend upon successful piloting and testing of SUS and all provider organisations submitting data. In addition there will be a number of conditions around the data that will have to be satisfied in order for us to allow the switch over, particularly around completeness and accuracy of data flowing via SUS. At this stage, we do not have a set date by which this switch over will take place and we will continue to liaise and work with SHAs and users in progressing this."*

Our status reflects the London picture in that we still have extensive data cleansing and validation to undertake. We do have an action plan to correct not just the output but also any technical constraints that may impact. The final and most important part of our action plan is to get the data correct first time. We are targeting re-training to areas of poor quality data as well as reviewing the process whereby communication of performance is fed to the correct area for immediate action or prevention.

5. DISCHARGE SUMMARY TARGET

5.1. The December 2009 Monthly Discharge Summary target performance has improved to 92% overall. .

5.2. Performance on discharge summary completion within 48 hours for the month of Decmember was 93% for inpatients and 92% for daycases.

5.3. In 2010/11 the target will be for 100% of discharge summaries to be completed and sent within 24 hours. We are currently at 82% within 24 hours.

6. CHOOSE AND BOOK

6.1. Slot availability is measured by the proportion of bookings where there were no slot issues and the appointment was made successfully. In 2008/09 the target was 80%. Average performance for the year to date is 69.9% and December was 75.0%. This significant improvement on November's performance is a result of a number of detailed local discussions where specialties have been asked to ensure all of their outpatient capacity is loaded onto the Choose & Book system.

6.2. The number of services that are on C&B as directly bookable are 87% at the end of December. (The target for this indicator in 2008/09 was 60%).

7. EFFICIENCY (AND OTHER TARGETS)

7.1. At the end of December 94.53% of clinical coding was being completed within the 7 day target. The internal target for the year is 98%.

7.2. Efficiency and Use of Resources –

- The Trust's daycase rate for a basket of procedures identified nationally as priorities is 70.8% year to date which is an improvement on last year's performance of 67.1% but is still below 75th percentile performance nationally of 72.9%.
- The percentage of outcomes recorded in outpatients is at 92.9% compared with 94.5% for the previous year.

8 HUMAN RESOURCES PERFORMANCE

8.1 Performance against key HR Metric targets are outlined in the table below.

HR Metric	Target	2008/2009	Year to Date
Turnover rates	14%	16.71%	**14.71%** (rolling 12mths : Jan 09 – Dec 09)
Stability rates	97%	95.9% (excluding Jnr Drs)	**96.64%** (excl Jnr Drs : rolling 12mths : Jan 09 – Dec 09)
Vacancies: total	10%	12.28%	**15.19% avg**
active	4%	n/a	**4.42% avg**
Sickness absence rates	3.75%	3.70%	**3.21% avg** (April 09 – Nov 09)

Red - below target and below 2008/09
Amber – below target but above 2008/09
Green – above target and above 2008/09

8.2 In December, the Trust staff inpost decreased slightly, down by 13.79 wte in comparison to the previous month. This is due to less recruitment over the Christmas period, with less joiners and less adverts than usual being placed.

Nonetheless, the substantive employed workforce has increase by 160wte (6.2%) since December 2008

Unplanned turnover (ie: resignations) increased in December, now at 1.01**%.**

Turnover for the twelve month period ending December 2009 was 14.71%

8.3 The Trust's vacancy rates are calculated using the budgeted wte (based on reconciliations with the Finance department), and the wte staff inpost at the end of the month. This represents the 'total vacancy' position.

The full Trust vacancy rate for December 2009 showed a marginal increase on the previous month, up to 14.43%. This represents a 3.3**%** increase on the same period in the previous year.
The year to date figure 15.19%.

A truer measure of vacancies is those being actively recruited to, based on unique jobs being advertised through NHS jobs throughout November. The year to date average active vacancy rate is 4.42%

8.4 The Trust's sickness rate showed a 0.74% increase in November, up to 4.13%, although year to date the sickness absence rate is 3.2%.

The number of sickness days by department (cost centre) and short/long-term absence is available in the 'Monthly Sickness by Department' report.

8.5 The Trust has seen another good decrease in Bank and Agency usage for December 2009, with total usage down 23.13 wte on last month. Agency usage is down 38% on this time last year. (74.76 wte)

9 SLA PERFORMANCE AND ACTIVITY

Due to constricted timelines, this information is not ready at the time of writing this document. The information will be included in the Board Finance report.

10 CONCLUSION

10.1 We are meeting all Monitor targets so far in quarter 3.

10.2 The Trust is currently at a 'fully met' rating for existing and national targets for the Care Quality Commission (CQC). The only area we are underperforming in is Inpatients waiting longer than the 26 week standard, where we have had 6 breaches in the year so far and are 0.01% above the threshold. We also need to ensure we avoid any further patient cancellations for non-clinical reasons which we do not treat within 28 days.

Monitor December 2009

Monitor Indicators								
Indicator Name	**YTD Target**	**Q1 (M1 to M3) Performance**	**Q2 (M4 to M6) Performance**	**Q3 Performance (M7 to M9)**	**Q4 Performance (M10 to M12)**	**Score Year to Date**	**Score Expected at Year End**	**Weight of Indicator**
Clostrium difficile cases	73	7	17	5		1.0	1.0	1.0
MRSA cases	4.8	1	4	4		1.0	1.0	1.0
18 Week Maximum Wait for Admitted Patients from Point of Referral to Treatment*	90%	93.07%	94.69%	93.65%		1.0	1.0	1.0
18 Week Maximum Wait for Non Admitted Patients from Point of Referral to Treatment*	95%	98.86%	98.96%	98.99%		1.0	1.0	1.0
Max time in A&E of 4 hours from arrival to admission, transfer or discharge	98%	98.64%	98.67%	98.30%		0.5	0.5	0.5
Screening all elective in-patients for MRSA	1.0	1.30	1.36	1.44		0.5	0.5	0.5
31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	96%	100.00%	99.08%	97.92%		0.5	0.5	0.5
31-Day Wait For Second Or Subsequent Treatment: Surgery	94%		96.49%	100.00%				
31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	98%		100.00%	100.00%		1.0	1.0	1.0
62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	85%	96.23%	97.65%	92.03%				
62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	90%	N/A	N/A	N/A		1.0	1.0	1.0
All Cancer Two Week Wait	93%	97.88%	97.2%	95.95%		0.5	0.5	0.5
People suffering heart attack to receive Thrombolysis within 60 mins of call		N/A	N/A	N/A				
						8.0		**8.0**

Key		Total Score
The Trust is on track to meet this target	(green)	<1
It does not seem likely that the Trust will meet this target.	(red)	1+
It is not possible to accurately assess performance in this area.		

**** The Operating Framework sets the aim of moving towards achievement of these target in each specialty. Where an NHS foundation trust has failed to meet the thresholds for admitted (90%) or nonadmitted (95%) patients with respect to any individual speciality (defined as treatment function) over a quarter it is required to report each specialty to Monitor as part of its normal quarterly monitoring. Monitor may then require an action plan from the Trust to address the position.***

Council of Governors Meeting, 3 February 2010

AGENDA ITEM NO.	3.3/Feb/10
PAPER	Care Quality Commission Registration
AUTHOR	Catherine Mooney, Director of Governance and Corporate Affairs
LEAD	Catherine Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	This paper introduces the new requirements for registration with the Care Quality Commission, the process for assessing compliance and the outcome of the review. The Board agreed with the declaration of compliance with all standards for all regulated activities.
DECISION/ ACTION	For information.

Care Quality Commission Registration

1. Introduction

This paper introduces the new requirements for registration with the Care Quality Commission, the process for assessing compliance and the outcome of this process.

2. Background

New essential common quality standards will replace Standards for Better Health. All NHS trusts who provide regulated activities must be registered with the Care Quality Commission from April 2010, Adult social care and independent healthcare providers will follow from 1 October 2010. The new system is focused on outcomes rather than systems and processes and places the views and experiences of people who use services at its centre. The CQC will seek information from patients and public representative groups and from organisations and other regulators and the National Patient Safety Agency.

3. Registration

Registration includes initial registration, monitoring and checking of ongoing compliance, inspection and enforcement.

The legislation that underpins the new registration system is the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009.

Trusts are required to apply for registration between 4th and 29th January 2010.

In a letter to Chief Executives, the CQC state ‘ we are absolutely committed to reducing bureaucracy and any unnecessary burden of regulation on providers. It is our expectation that trusts should already be meeting essential standards. They relate to important aspects of care that good trusts will already be providing, such as involvement and information for people, personalised care and treatment, safety and safeguarding. We do not, therefore, anticipate that the majority of trust will have to implement additional actions in order to be compliant.’

3.1 Locations and regulated activities

The Care Quality Commission consider the locations other than Chelsea and Westminster are satellites and we only need to register C&W as one location. The regulated activities which apply to us are:

Treatment of disease, disorder or injury
Surgical procedures
Diagnostic and screening procedures
Maternity and midwifery services
Termination of pregnancy
Assessment or medical treatment for people detained under the Mental Health Act 1983

It is necessary to declare compliance or not against each regulated activity for each standard. In practice we will consider the services as a whole unless we have reason to think otherwise.

3.2 Regulations, outcomes and prompts

The CQC have produced guidance to help providers of health and social care to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 and the Care Quality Commission (Registration) Regulations 2009.
The CQC have linked the regulations to outcomes and prompts. There are 28 outcomes, each reflecting a specific regulation. The outcomes are expressed in terms of what users of the service might expect. Of the 28 regulation and outcomes, there are 16 that relate most directly to the quality and safety of care and which apply to all types of provider. The other 12 regulations may apply differently to different types of provider.

The 28 outcomes are grouped into six key areas:

- Involvement and information
- Personalised care, treatment and support
- Safeguarding and safety
- Suitability of staffing
- Quality and management
- Suitability of management

There are some links between Standards for Better Health (SfBH) and the new standards.

3.3 Registration on the website

The following is an extract from the website which gives further context for the registration;

Declaration of compliance
The guidance for compliance for providers illustrates how each of the requirements may be reliably met. Providers may decide on alternative approaches but should be prepared to justify and evidence to the Care Quality Commission how the chosen approach is equally or more effective in ensuring the regulations are met.

This form is asking you to declare whether you are fully compliant or non-compliant with the Registration ***Regulations*** *(my bold* **)***relevant to the regulated activities you provide. A provider who will be compliant with the registration requirements will meet the* ***outcomes*** *(my bold) for people who use services as set out in the guidance about compliance. A provider who is non-compliant has not met elements of the registration requirements as described by the outcome statements in the guidance about compliance. Evidence to support the declaration must be available on request. You must complete a declaration of compliance for each location in which you wish to carry out regulated activities.*

For each of the regulations where you identify you are non compliant you will need to tell us:
-The ways in which you are non compliant
-What you will do to become compliant
-When you will become compliant
-How you will sustain your level of compliance

The next page lists 'regulated activity: Treatment of disease disorder or injury

A list of regulations 9 to 24 follows with the option to declare compliant or non compliant.

The process is then repeated for the next regulated activity, which is surgical procedures and so on.

4. Quality and Risk profiles (QRP)

When assessing a trust's application the CQC will use a tool called a 'quality and risk profile' that gathers all that is known about a provider in one place. This will enable the CQC to assess where risks lie and support judgements about the quality of service. The QRP contains data from external sources i.e. staff survey, in-patient survey, NHSLA Risk Management Standards assessment, national priorities, existing commitments, Patient Experience Action Team (PEAT) Counter Fraud and Security Management Services (CFSMS) and the HSE Enforcement notice database. Trusts are assessed against a number of elements of these sources as green amber or red and areas of concern highlighted. This was considered by the Board.

5. Process for assurance on compliance with standards

Due to the time constraints a high level review of the regulations, outcomes and prompts has been undertaken by the directors (and chief pharmacist). Each lead reviewed the relevant regulations, the outcome description (and the prompts), considered the relevant SfBH (some link better than others) and considered the quality and risk profile. A table of evidence against each standard is being prepared using the prompts for a guide but with emphasis on the outcomes. Each director assessed whether the Trust is compliant with the regulations for which they are responsible with the option to highlight any areas for further consideration.

6. Outcome of review

The outcome of the process highlighted above is that the directors and chief pharmacist have confirmed that we can declare compliance with each of the standards for each regulated activity. Areas to consider further have been highlighted. An evidence template is available. The Board supported the declaration of compliance with all standards for all regulated activities.

7. Next steps

The standards and prompts will be reviewed in more detail by leads and evidence evaluated against each prompt. This will be built into the work plan of the Assurance Committee.