Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting
Hospital Boardroom
Chair: Prof. Sir Christopher Edwards
Date: 18 July 2013 Time: 4.00pm

Agenda

		Lead	Time
1	**GENERAL BUSINESS**	**CE**	
1.1	Welcome & Apologies	CE	4.00
1.2	Announcement of election results	CE	
1.3	Declaration of Interests	CE	
1.4	Minutes of Previous Meeting held on 23 May 2013 draft (attached)	CE	
1.5	Matters Arising (attached)	CE	
1.6	Chairman's Report (oral)	CE	
1.7	Chief Executive's Report (oral)	DR	
1.8	Feedback from Board	CE	4.20
2	**ITEMS FOR DISCUSSION/DECISION/APPROVAL**		
	GOVERNANCE		
2.1	Update on Board of Directors' Appointment	CE	4.25
2.2	Presentation of Annual Accounts & Annual Report 2012/13 (attached)	CML/CE	4.35
2.3	External Auditors' Report on the Annual Accounts 2012/13 (attached)	BS	4.45
2.4	Findings and recommendations from the 2012/13 NHS Quality Report External Assurance Review (attached)	BS	4.55
2.5	Audit Committee Annual Report 2012/13 (attached)	GM	5.05
2.6	*Membership Engagement and Communication – update (attached)	KD-D	
2.7	Membership Recruitment, Engagement and Communications Strategy 2013/14 (attached)	KD-D/SN	5.15
2.8	Annual Members' Meeting Proposal (attached)	KD-D	5.25
2.9	Musical entertainment and art in the hospital (oral)	TH	5.35
	COUNCIL OF GOVERNORS		
2.10	Governors' Questions (attached) - Counterfeit medicines (AH-P) attached - Homecare (HM) (attached) - Update on progress on arranging the official opening of the Ron Johnson ward, perpetuating the name Thomas Macaulay ward and commemorating Jim Smith (CBir) (oral) - Goods on sale on the hospital ground floor (HM) (oral)		5.45
2.11	*Council of Governors Funding Report (attached)	CM	
2.12	*FTGA/NHS Confederation joint event - NEDs and Governors: How to build effective working relationships – 22 April 2013 (attached)	SM	
2.13	Palliative Care (attached)	CBir/AH-P	5.55
	QUALITY		
2.14	Embedding Trust values – governors values/behaviours (attached)	CD	6.00
2.15	Francis Inquiry Report update on progress (attached)	DR	6.10
2.16	Quality Awards (attached)	CE	6.15
2.17	*Quality Sub-Committee report (draft minutes of 13 June 2013 meeting attached)	CM	
	MEMBERSHIP		
2.18	*Membership Sub-Committee report (draft minutes of 2 July 2013 meeting attached)	ML	
2.19	*Membership Report (attached)	SN	
2.20	*Open Day 11 May 2013 – Evaluation Report (attached)	KD-D	

3	**ITEMS FOR INFORMATION**	
3.1	A copy of the Finance and Performance Reports are available via Board papers which are available on the website at the following link: http://www.chelwest.nhs.uk/about-us/organisation/trust-meetings and a hard copy of the board pack in the governors' room	
3.2	FTGA Significant transactions: a guide	
4	**ANY OTHER BUSINESS**	6.20
5	**DATE OF THE NEXT MEETING – 19 September 2013**	
	CLOSE	6.30

***Items that have been starred will not be discussed unless a prior notice has been given to the Chairman**

DR – David Radbourne, Chief Operating Officer (in place of Chief Executive)
BS – Benjamin Sheriff, Deloitte
GM – Non-executive Director
CML – Carol McLaughlin, Financial Controller/Acting Deputy Director of Finance (in place of Lorraine Bewes)
TH – Trystan Hawkins, C&W Hospital Charity Art Director

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Council of Governors Meeting, 18 July 2013

AGENDA ITEM NO.	1.2/Jul/13
PAPER	Announcement of Council of Governors election results
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper provides the Council of Governors election results
DECISION/ ACTION	To note.

Chelsea and Westminster Hospital NHS
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Council of Governors election results
July 2013

Patient Governors

- Chris Birch – re-elected
- Dr Charles Steel – due to an additional vacancy which arose in May the second highest polling candidate has been invited to fill in that seat and serve for a three-year term as agreed at 23 May Council of Governors meeting.

Public Governors

- Hammersmith and Fulham Area 1 – Samantha Culhane (re-elected unopposed)
- Kensington and Chelsea Area 1 – Capt. Edward Coolen

Staff Governors

- Management – Dominic Clarke – elected

Chelsea and Westminster Hospital NHS
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Council of Governors Meeting, 18 July 2013

AGENDA ITEM NO.	1.4/Jul/13
PAPER	Draft Minutes of Council of Governors Meeting – 23 May 2013
AUTHOR	Vida Djelic, 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
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Council of Governors Meeting Minutes, 23 May 2013
Draft

Prof. Sir Christopher	Edwards	Chairman		CE
Walter	Balmford	Patient		WB
Chris	Birch	Patient		CBir
Christine	Blewett	Public	Hammersmith and Fulham 2	CBle
Nicky	Browne	Appointed	The Royal Marsden NHS Foundation Trust	NB
Anthony	Cadman	Patient		ACa
Alan	Cleary	Patient		ACle
James	Dennis	Staff	Allied Health Professionals, Scientific and Technical	JD
Brian	Gazzard	Staff	Medical	BG
Jenny	Higham	Appointed	Imperial college	JH
Melvyn	Jeremiah	Public	Westminster 2	MJ
Martin	Lewis	Public	Westminster 1	ML
Kathryn	Mangold	Staff	Nursing and Midwifery	KM
William	Marrash	Patient		WM
Susan	Maxwell	Patient		SM
Harry	Morgan	Public	Wandsworth 1	HM
Sandra	Smith-Gordon	Public	Kensington and Chelsea 2	SS-G
Frances	Taylor	Appointed	Royal Borough of Kensington and Chelsea	FT
Maddy	Than	Staff	Support, Admin & Clerical	MT
Alison	While	Appointed	Kings College	AW
Steve	Worrall	Public	Wandsworth 2	SW

IN ATTENDANCE:

Sir John Baker	Non-executive Director	JB
Sir Geoffrey Mulcahy	Non-executive Director	GM
Karin Norman	Non-executive Director	KN
Tony Bell	Chief Executive	APB
Therese Davis	Chief Nurse and Director of Patient Experience and Flow	TD
Lorraine Bewes	Director of Finance	LB
Catherine Mooney	Director of Governance and Corporate Affairs	CM
Zoe Penn	Medical Director	ZP
Katie Drummond-Dunn	Communications Manager	KD-D
Layla Hawkins	Head of Communications and Marketing	LH
Vida Djelic	Foundation Trust Secretary	VD
Patricia Gani	Healthwatch representative	PG
Paula Murphy	Interim Director Healthwatch	PM
Mark Harris (in part for item 2.5)	Business Development Lead	MH
Paul Morris (in part for item 2.10)	Lead Nurse, Mental Health	PM

1 GENERAL BUSINESS

1.1 Welcome & Apologies CE

CE welcomed Layla Hawkins, new Head of Communications and Marketing to the meeting.

CE welcomed PG and PM from Healthwatch to the meeting and noted that they will present item 2.12. CE also welcomed the members of the public to the meeting.

CE expressed sadness at the sudden death of Tera Younger, patient governor. He expressed appreciation for all her hard work and would like the contribution she made to be minuted.

Apologies were received from Julie Armstrong, Tom Church, Sam Culhane, Anna Hodson-Pressinger and Wendie McWatters.

CE noted that he had received Dr Cadman's view on mergers/acquisitions via the FT Secretary. He confirmed that any acquisition would have to be approved by the Council of Governors.

APB noted that the Trust is undertaking due diligence in relation to the acquisition of West Middlesex Hospital and will include consideration of the consequences of not acquiring it i.e. that Imperial Healthcare might merge with West Middlesex Hospital.

HM queried if patient care has been considered as part of due diligence. CE confirmed that Monitor has clear guidance on this and any acquisition has to be financially viable and of benefit to the patients. He also confirmed that there would be one budget.

CE proposed that the item 2.1 Re-appointment of the Chairman and NED should be discussed at the end of the meeting. **This was agreed.**

1.2 Declaration of Interests CE

None.

1.3 Minutes of Previous Meeting held on 14 February 2013 CE

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

- p.4, section 2.3 change 'corporation' to 'Trust'

1.3.1 Agree style and format of minutes

The governors discussed the style and format of minutes and agreed that it is important that the minutes record who said what and as they represent the patient and public members it is important to be able to identify individual contributions. It was also agreed to keep minutes shorter.

CE concluded that minutes must record all decisions and the main points especially if controversial and a summary of the main points on which decision was made. This was agreed.

HM suggested that the papers for the Council of Governors meetings should be simpler and smaller in size. CE agreed that whenever possible the papers should be simplified.

NB commented that when responding to emails there is no need to copy all members in a response.

1.4 Matters Arising **CE**

Ref 2.4.2 Nominations Committee of the Council of Governors for the Appointment of NEDs – expression of interest
CE noted that at the February Council of Governors meeting it was agreed that the membership of the Nominations Committee for appointment of Non-executive Directors and Chairman would consist of two elected governors and one appointed governor. CE noted that following on the interviews held earlier in May, TC and BG have been selected for the membership of the committee. Jenny Higham had subsequently been invited to be an appointed governor representative and Jenny Hill, a NED at the Royal Brompton Hospital to be an external assessor.

Ref 2.17 Membership Report
It was noted that this update was misleading as it suggested that there was no further action but in fact it will be discussed again at the next membership meeting.

CE noted following on C&W being selected as a preferred provider of A&E, under the Shaping a Healthier Future consultation, the Trust is at the planning stage of refurbishing A&E facilities.

SS-G asked for an update on the role of PALS. **APB to provide an update at the next meeting.** **APB**

CBir queried the timeline for further review of the constitution and that the Away Day notes and Board minutes record it would be done in May. CM responded that the timeline had been overly optimistic and that a date needed to be agreed.

1.5 Chairman's Report (oral) **CE**

CE reported on a recent meeting with Prof Sir Brian Jarman who runs the Dr Foster Unit at Imperial and who is an expert on producing quality data. CE outlined the importance of data and if more patients move to the community we must have an idea of what is happening to them.

He also noted that a successor to Prof Kotch would be announced soon and that Jane Lawson, Director of Development at the Victoria & Albert Museum agreed to support Chelsea and Westminster Hospital Charity.

It was requested that the next Away Day should not be just before Christmas.

1.6 Chief Executive's Report (oral) **APB**

APB noted that the previous financial year accounts were good and congratulated the finance team and other staff who made it possible.

APB noted that the Star Awards event held on 18 April was very positive and the governors' award a vital part of it. Other awards were described in Trust News.

APB recorded thanks to governors for the support with organising the Open Day and noted Wendie McWatter's contribution regarding the special guest invitation and Sandra Smith-Gordon, Frances Taylor, Martin Lewis and Susan Maxwell, for their particular contribution on the day.

APB noted that the work on strategy continues and the paper which relates to the Trust plan for submission to Monitor will be presented later in the meeting.

It was noted that the Shaping a Healthier Future is awaiting the Secretary of State for Health's decision.

A&E has been in the news recently; we remain top of London Trusts for A&E performance.

The Royal Brompton Hospital partnership work continues.

In response to a question from ML re the timeline for official opening of the Chelsea Children's Hospital, APB responded that it is likely to be early next year.

In response to a question from HM re the da Vinci robot, CE responded that the Trust is aiming to maximise the use of da Vinci robot and plans to extend its use to other parts of the hospital.

1.7 Feedback from the April Board **CE/ML**

It was noted that this was the first open Board and an opportunity for the public to attend.

CBir commented that he did not get the impression that the Board works as a team, the Chief Executive talked and the other executive directors did not take part in discussions and it looked as if they only responded to questions from the Non-executive Directors. ABP responded that there is executive contribution and that the perception from the public about the Board meeting might be slightly different, as it is just one point in time.

In response to a comment on the venue of Board meetings from ML, CM said that the May Board will be held in the Hospital Restaurant and the venue for future Board meetings will be considered further depending on attendance.

2 ITEMS FOR DISCUSSION/DECISION/APPROVAL

2.1 Re-appointment of the Chairman and NED **JB**

There was a brief discussion regarding the Nominations Committee for

appointment of Non-executive Directors and a Chairman.

JB noted that a proposal has been put forward to governors that a Non-executive Director sits on the Nominations Committee for the appointment of Non-executive Directors and Chairman. The NED would have an advisory role and would not have any voting rights. This was to be discussed later in the meeting.

SM quoted Governance on the external adviser not being a voting member. (It was clarified later in the meeting that the external advisor would not have a vote).

CE confirmed that the appointment of NEDs is the remit of the Council of Governors through the Nominations Committee and it was entirely up to the Council of Governors to accept or not accept any process proposed.

2.1 Re-appointment of the Chairman **JB**

The following discussion took place at the end of the meeting without the Chairman present

JB presented a proposed plan for the recruitment of new Non-executive Directors and a Chairman Designate. It was also proposed that the term of the office of the Chairman and Non-executive Director Karin Norman is extended for one further year.

The Council of Governors discussed the proposal.

It was confirmed that the first stage would be to select a recruitment agency. As previously they would produce a longlist and then a shortlist would be agreed.

ML queried a possible conflict regarding Jenny Higham being a member of the Nominations Committee and being a Non-executive Director of the West Middlesex Hospital. There was some confusion regarding the appointed governor representative and the external assessor and this was agreed to be clarified and any conflict of interest to be determined. (This is as reported earlier in the minutes ref matters arising ref 2.4.2).

It was confirmed that the external advisor would not have a vote.

JB said that in relation to voting, if that was necessary then the process will have failed as he would work to achieve a consensus. However, the governors have a clear majority on the Nominations Committee and will decide the outcome.

It was confirmed that the Board had not agreed a person specification and that a skills analysis was being undertaken of the Board currently to identify gaps. This would be used to inform the Nominations Committee what type of person was appropriate.

The Council of Governors agreed to an extension of Prof Sir Christopher Edwards' and Karin Norman's office for a term of one year ending on 31 October 2014.

The Council of Governors also agreed to a Non-executive Director attending

and providing advice to, the Nomination Committee meetings.

The Council of Governors also agreed to the proposal that all the shortlisted candidates should have been seen by the Chief Executive and NEDs prior to the final interview process, with their comments on the short listed candidates being available to the Nominations Committee.

2.2 Francis Inquiry Report **TD**

CE highlighted positive views received from a governor on a recent experience of our A&E department which were that the staff and service were excellent.

TD noted that the paper provides a summary of the Francis Inquiry which has made 290 recommendations designed to change the culture and make patients come first by creating a patient centered culture across the NHS.

TD highlighted that the Trust has held some listening events, to listen to front line staff. Following the listening events themes will be identified and fed back to the Quality Committee and an action plan will be developed. A copy of listening events dates organised for May and June was tabled. All governors were invited to attend.

In response to a question from ML on feedback from the listening sessions held, TD said that these were about how we can create a zero tolerance over issues such as bullying, Never Events and also about challenging poor behaviour.

In response to a question from SM on whether the values have had an effect TD said that a change of culture takes time and it has been recognised that some areas already provide excellent patient care. It was noted that the Trust has had meetings with professionals from the commercial sector regarding 'good customer care'.

ML commented that he has recently had experience of A&E at the Chelsea and Westminster Hospital. His experience at the reception desk suggested some improvements were necessary. TD said that the Trust is doing some work with Disney and McKinsey on outpatients in order to improve patient experience. NB commented that the first impression is very important and this is often achieved with the lowest grade staff so these staff should be supported with training.

In response to a question from CN, CE confirmed that a GP service is available in A&E.

CE noted that he has recently sent a letter to Mike Spyer, Chairman of NHS London outlining the steps taken by the Trust to ensure that staff and patients views are listened to and to inform Trust's views on the quality of its services. WB congratulated CE on the letter.

CE noted that TD is leaving the Trust in June and joining the Local Education and Training Board (LETB). He thanked her for all hard work and contributions to the Trust.

2.3 Quality Account Update **CM**

This item was starred and therefore taken as read.

2.3.1 Approval of the Commentary **MJ**

MJ explained that the Quality Account forms part of the Quality Report which is submitted to the Department of Health. MJ said this was an enormous piece of work and we owe CM and Melanie van Limborgh a tremendous vote of thanks for producing the report. He highlighted that the Council of Governors commentary features as an annex at the end of the report. The commentary was produced by the Council of Governors Quality Sub-Committee and the whole Council of Governors was asked to endorse the commentary. **This was agreed.**

APB said that mandatory training is also of concern to the Board and noted that it features on weekly and monthly performance reports. Appraisal rate is also something that is closely monitored.

2.4 Quality Sub-Committee Report **CM**

This item was starred and therefore taken as read.

2.5 Annual Plan 2013/14 **APB**

MH outlined the background of the paper and noted the strategic context within which the Trust operates, the main priorities and actions underpinning the clinical strategy.

It was noted that the overall demographics is staying consistent and A&E attendances and emergency admissions will keep increasing.

The Trust is working on reducing follow-up appointments and some specialist procedures.

WM queried if the increased A&E attendances relate to the same issue as recently written in the press. MH said that the Trust has noted an increase in A&E attendances and there is a range of factors impacting on this and the full picture needs to be clarified.

In response to a question from ML regarding income generation, CE responded that the Trust is going to appoint a Commercial Director to assist with this and that more innovation rather than investment was required.

The Council noted the contents of the annual plan which will be signed off by the Board on 28 May 2013 and submitted to Monitor on 30 May 2013.

CE thanked MH for presenting a very useful paper.

2.6 Governors' Questions

A written response to the questions from governors was provided with the exception of 2.6.1.

APB noted that the Trust has approached another VIP in relation to the official opening of the Ron Johnson ward. The official date will be confirmed in due course.

BG said in relation to the memorial plaque that there had been a meeting of volunteers but no agreement had been reached. In relation to perpetuating the name of Thomas Macaulay ward BG confirmed that the conservatory on Ron Johnson ward will be redesigned and a plaque will be put up to commemorate special contributions.

APB confirmed that the new plaque for Jim Smith will be commissioned to replace the missing one.

ML queried how far we are with health tourist income? LB replied that we do not charge for A&E and the Finance and Investment Committee has taken a strong interest in maximising what we can recover. We have taken steps to put in credit card facilities and some areas need specific information relating to whether a patient is eligible for NHS care. We expect to see an increase in income.

ACle noted his dissatisfaction regarding his request for background information.

2.7 Council of Governors Performance Evaluation Report – response to questionnaire **CE**

CE thanked those who responded and noted that the results were compared with Monitor results. Most of results were similar to Monitor results and the area, for improvement was highlighted.

The Council of Governors was asked to consider and identify actions to be taken forward. **All**

2.8 Report on Senior Nurse/Governor Rounds **TD**

TD noted that Tony Pritchard, Deputy Chief Nurse met with some governors to discuss the format of governors' visits to clinical areas.

CE highlighted that a CRB check will need to be completed in order to be able to visit clinical areas.

A list of clinical areas and specialties was tabled for governors to note their areas of interest. GU Clinics had been left off by mistake.

2.9 Open Day 11 May – feedback **KD-D**

Highlights of the Open Day included that circa 2,049 people attended and circa 107 members were recruited. 98% of those attending said it was an excellent event and 98% would recommend it to friends and family.

ML congratulated the communications team on organising a successful Open Day.

2.10 Funding Report

The Council of Governors funding report was noted.

Paul Morris, Lead Nurse, Mental Health presented a proposal to purchase MyLife Reminiscence Software which is touch screen technology that enhances the life of those with dementia. It helps learning and creating life stories/experience and photographs can be uploaded. It also helps carers and family members communicate more effectively.

The initial proposal is to purchase two units and two trollies to enable patients who are bed bound to participate in the activities at the cost of £5,370.

The Council of Governors discussed the proposal and whether the Council of Governors should fund it.BG said that it should not necessarily get priority over other schemes because it had been brought to the Council of Governors.

SS-G suggested that this project could be funded by Friends.

CE concluded that the Council of Governors support the proposal in principle and the funding will be discussed further with the APB. **CE to discuss funding source with APB.** **CE**

2.11 The tenth FTGA National Development Day 14 March 2013 – feedback **ACle/SM**

The report was taken as read.

In response to a question from SS-G regarding including copies of a long presentation in the governors pack SM responded that she felt that the detail was very useful.

2.12 Healthwatch Kensington and Chelsea Report **PM**

Paula Murphy, Interim Director, Healthwatch Central West London updated the governors on the recent change from the Local Involvement Network (LINk) to Healthwatch. Healthwatch is a legal entity which LINk was not and will be known as Healthwatch Central West London.

It was noted that Healthwatch will continue engagement with the Council of Governors, Council of Governors Quality Sub-Committee and the Council of Governors Membership Sub-Committee.

It was also noted that Healthwatch has a statutory seat on the Health and Wellbeing Board and on relevant scrutiny committees. It has membership of circa 3,000 members and aims to expand across the borough.

SW asked how it relates to Wandsworth and that we might want a relationship with another Healthwatch as well.

CE said we need clarity on what organisations will be doing in order to avoid duplication.

CE concluded that he was looking forward to the Trust and Healthwatch working together and thanked PG and PM for presenting.

2.13 C&W Election to the Council of Governors **CBir**

This paper was noted.

2.13.1 C&W Election to the Council of Governors – communication plan **VD/LH**

Governors noted the election timetable.

VD highlighted that since the election process started one more patient seat has become vacant and as suggested by CBir at the Membership Sub-Committee it was proposed that the Trust takes on the next highest polling candidate for that seat. **This was agreed.**

LH noted that a draft communication plan was presented to the Membership Sub-Committee at its meeting held on 16 May 2013. The communication plan was endorsed by the sub-committee.

2.14 Membership Sub-Committee report **ML**

This item was starred and therefore taken as read.

2.15 Membership Engagement and communication – update **KD-D**

This item was starred and therefore taken as read.

2.16 Membership Report **TD**

This item was starred and therefore taken as read.

3 ITEMS FOR INFORMATION

Noted.

4 ANY OTHER BUSINESS **CE**

SS-G complained about the signage in the front of the hospital using 'hideous' fake wood surround.

In relation to a question from a governor regarding the kinesiology offer to staff via the daily bulletin it was confirmed that this should not have been included.

A member of the public raised the question of where the plaque of Mary Seacole had gone. **It was agreed that this would be investigated.**

FTN Training Courses

VD emphasised the importance of governors attending the FTN training courses and that foundation trusts are required under the Health and Social Care Act 2012 to take steps to ensure that governors are equipped with the skills and knowledge they need. A copy of the FTN training courses dates for 2013 was tabled.

5 DATE OF THE NEXT MEETING

The next meeting of the Council of Governors will be held on 18 July 2013.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 18 July 2013

AGENDA ITEM NO.	1.5/Jul/13
PAPER	Matters Arising from the meeting of the Council of Governors meetings held on 23 May 2013
AUTHOR	Vida Djelic, 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: 23 May 2013
Time: 4:00 – 6:30 pm

Ref	Description	Lead	Subsequent Actions or Outcomes
1.4/May/13	**Matters Arising**		
	SS-G asked for an update on the role of PALS. **APB to provide an update at the next meeting.**	**APB**	
2.7/May/13	**Council of Governors Performance Evaluation Report – response to questionnaire**		
	The Council of Governors was asked to consider and identify actions to be taken forward.	**All**	
2.10/May/13	**Funding Report**		
	CE concluded that the Council of Governors support the proposal in principle and the funding will be discussed further with the APB. **CE to discuss funding source with APB.**	**CE**	

Chelsea and Westminster Hospital NHS
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Council of Governors Meeting, 18 July 2013

AGENDA ITEM NO.	2.1/Jul/13
PAPER	Update on Board of Directors' Appointment
AUTHOR	Fleur Hansen General Manager for the CEO
LEAD	Prof Sir Christopher Edwards, Chair
EXECUTIVE SUMMARY	This paper is to provide the Council of Governors with a brief update on the recruitment process for the forthcoming Board of Directors appointments. The paper also details the Board's intention to ensure the important links between the Board and Imperial College are retained going forward.
DECISION/ ACTION	The Council of Governors is asked the following: • To NOTE the recruitment schedules. • To AGREE to extend Prof Kitney's Non-Executive appointment until such time as a suitable replacement is formally appointed by the Council of Governors. • To NOTE that an Imperial College representative will be in attendance at the Board meetings and that Prof Kitney will take on this role initially once the replacement NED is appointed.

UPDATE ON BOARD OF DIRECTORS' APPOINTMENTS

1.0 Introduction

1.1 This paper is to provide an update to the Council of Governors on the Board of Directors appointment process.

1.2 It was agreed at the Council of Governors May meeting to extend the appointments of Prof Sir Christopher Edwards and Miss Karin Norman for an additional year to ensure appropriate succession planning is in place.

1.3 It was also agreed at the May meeting to commence the recruitment process for new NEDs – one NED to replace Prof Kitney whose term finishes in October 2013 and two proleptic NEDs, one of whom will be the chair designate, who will commence formally in post in October 2014.

2.0 Update on Recruitment Process

2.1 As the Council is aware, the Council of Governors' Nominations Committee will be leading the process, with support provided by the corporate affairs and HR teams.

2.2 The recruitment schedules for the chair designate and the NED are attached as Appendix 1. As noted previously, these will be two separate processes which although aligned, will be chaired by the Sir John and Sir Christopher respectively. The other members of the Nominations Committees will be the same for both processes.

2.3 As noted on the schedules, expressions of interest from recruitment agencies have been sought and are being compiled in preparation for review by the Nominations Committee at the end of July. The agency selected by the Nominations Committee will then be retained for both the chair and NED recruitment process.

3.0 Succession Planning

3.1 As Miss Karin Norman's appointment has been extended by a year there is less sense of urgency to identify her replacement but given the recruitment process is in place for Prof Kitney and a chair designate, it seems appropriate to look to recruit to this post as well. If a suitable candidate is identified as part of this current recruitment process, then we would proceed with a proleptic appointment but the NED would not commence formally in post until October 2014, in line with the chair designate. This would allow for a period of induction to the Trust, the Board and the Council.

3.3 From the attached recruitment schedule it is apparent there will be a short time where the Board would be without a full quota of NEDs, until the new NED is formally appointed by the Council of Governors at the December meeting. Given this will be mean the Trust is not in line with its Constitution or Monitor guidance it is proposed that Prof Kitney is extended as a NED until the new NED is appointed and their start date agreed.

4.0 Imperial College Representation

4.1 The contribution of Prof Kitney as an individual but also as a member of Imperial College has been invaluable over the eight years he has served on the Board. The Board of Directors have always recognised this crucial link with Imperial College and since the Trust's inception, there has always been a representative of the College on the Board.

4.2 The Board would like to ensure this link to Imperial College is retained but without limiting the search for a NED to being a member of the College. It is therefore suggested that Imperial College should be asked to nominate a senior member of the academic staff to be in attendance at the Board meetings. This person will not be a NED and will not have voting rights but will attend meetings and provide input when required. This situation is equivalent to the current arrangements for some directors who are in attendance at Board meetings.

4.3 Prof Kitney has expressed an interest in being appointed to this role for one year. This will allow him to complete the important IM&T strategy work he has been leading for the Trust during 2014. We would then hold discussions with Imperial College to identify a suitable replacement for Prof Kitney.

5.0 Conclusion

5.1 In summary, the Council of Governors is asked the following:

- To NOTE the recruitment schedules.
- To AGREE to extend Prof Kitney's Non-Executive appointment until such time as a suitable replacement is formally appointed by the Council of Governors.
- To NOTE that an Imperial College representative will be in attendance at the Board meetings and that Prof Kitney will take on this role initially once the replacement NED is appointed.

APPENDIX 1

Recruitment process for Chair and NED

Nominations Committee for Chair: **Sir John Baker (chair)**
Brian Gazzard
Tom Church
Jenny Higham
Jeremy Loyd
Jenny Hill (independent advisor)

Nominations Committee for NED: **Prof Sir Christopher Edwards (chair)**
Brian Gazzard
Tom Church
Jenny Higham
Jeremy Loyd
Jenny Hill (independent advisor)

Activity	**Who**	**Timeline**	**Progress**
Shortlist Recruitment Agencies – EoIs	HR Director / Director of Corporate Affairs	Early July	
Agree Job profile/person specification (COG policy for composition of NEDs)	Nominations Committee/Board	July	
Select Recruitment Agency - agreement	Nominations Committee	Late July	
Review and update the Candidate Information Pack and Application Form	Trust/Agency	Late July/August	
Preparation for Advert and publish in local and national press	Agency	August/September	
Closing date for receipt of Applications	Agency	End September	
Long-listing meeting (2hrs)	Nominations Committee/Agency	October	
Short-listing meeting (2hrs) (to shortlist to max 5 candidates)	Nominations Committee/Agency	October	
1-2-1 with the CEO / selected NED for the shortlisted candidates (30mins each candidate)	Agency	October	
Interviews - include the external assessor (10am-4pm)	Nominations Committee/ Agency (wash-up session)	October/November	
Paper for CoG re appointments (COG meeting December)	Senior Independent Director (chair) Chair (NED)	12 December	

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 18 July 2013

AGENDA ITEM NO.	2.2/Jul/13
PAPER	Presentation of Annual Accounts & Annual Report 2012/13
AUTHOR	Helena Moss, Head of Technical Accounts
LEAD	Lorraine Bewes, Chief Financial Officer Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	The Trust had a successful financial year, ending the year with a surplus of £13m (EBITDA of 9.8%), £400k better than planned against the 12/13 financial target of a £12.6m surplus. Operating income increased by just under 1% to £345.9m. As last year, this delivered the highest level Monitor Financial Risk Rating of 5, exceeding the planned Financial Risk Rating of 4. The delivery of this financial position was underpinned by 100% achievement of the Trust's £16.2m Cost Improvement Programme for 2012/13 (representing 6% of controllable costs). The Private Patient Cap was lifted with effect from 1st October 2012 and instead the Trust was obliged to ensure that the income received from providing goods and services for the NHS (its principal purpose) was greater than the income from other sources. The Trust met this requirement in 2012/13, with 94% of total operating income in the year relating to the provision of goods and services for the NHS. The Trust did not exceed any of its prudential borrowing limit ratios, which was also a requirement of its Authorisation. The balance sheet position remained strong, with positive net current assets and cash holdings of £41.6m. This was after investment of nearly £16.8m (£33m 2011/12) on capital schemes which included: • The new Diagnostic Centre, bringing together in one

	purpose built centre many of the diagnostic services that were previously spread across the hospital; • The paediatric burns development on the first floor of the hospital • The paediatric surgical ward (opened April 2013) • Various IT and building maintenance schemes As a Foundation Trust, Chelsea and Westminster can use its cash surpluses to invest in the hospital's future developments. The Trust has an ambitious programme of capital development totalling approx. £138m over the next three years, which is being funded by a combination of cash surpluses, loans and PDC funding linked to the Shaping a Healthier Future plans. A hard copy of the Annual Report and Accounts 2012/13 will be available on the day.
DECISION/ ACTION	To note.

20 YEARS

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Annual Report & Accounts
2012/13

RESPECTFUL
KIND
SAFE
EXCELLENT

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

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

Chelsea and Westminster Hospital NHS Foundation Trust
Annual Report & Accounts 2012/13

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INTRODUCTION

Introduction from the Chairman and Chief Executive

2012/13 has been a landmark year for Chelsea and Westminster Hospital NHS Foundation Trust during a time of impending change to the structures of the NHS.

Our new Chief Executive, Tony Bell OBE, joined in September 2012 bringing a raft of healthcare experience both as a practising nurse and as a Chief Executive. We'd like to thank former Chief Executive, Heather Lawrence OBE, for her dedication and commitment in leading the Trust for 12 years and wish her well in her future endeavours.

There is a need across the NHS to centralise emergency services so that those who are critically ill can be treated by a senior doctor 24/7. While we can do this at the moment, there will in the future be a shortage of senior doctors specialising in Accident and Emergency (A&E) care across the country and without this rationalisation it would be unlikely that the NHS could provide a 24/7 service in every A&E Department. Changes to centralise stroke and heart attack care in specialist centres have over the past four years helped contribute to saving 400 lives each year across London.

The *Shaping a healthier future* project aims to address these challenges and, following public feedback, our hospital was chosen as one of five in North West London to retain major and local hospital status. This will mean that Chelsea and Westminster will continue to provide a full A&E service long into the future.

There will be a range of changes to NHS organisations and structures taking place from 1 Apr 2013. These changes will empower GPs to have a greater say in what hospital care is provided to their local populations with a greater focus on providing as much care in the community as possible.

Responsibility for public health has transferred to local councils, who already work to reduce socio-economic inequalities in their catchment area. And there will be a greater patient voice at the heart of the NHS, involved in local healthcare decision-making, with the development of Healthwatch on a local and national level.

We will work with health and social care colleagues and the communities we serve to make sure that Chelsea and Westminster Hospital NHS Foundation Trust provides the right services both in the community and, where required, in the hospital setting to help improve the standard of NHS care. This supports our long-term aim to become an accountable care organisation.

The Trust embraces the NHS changes taking place in 2013/14 and we are looking at our long-term future in the light of this changing landscape to ensure a bright future for the hospital. In 2013/14 we will be considering the possibility of a partnership with West Middlesex University Hospital NHS Trust to see if, by sharing our expertise and facilities, we could provide an even better service and experience. Equally important is our ongoing work to provide care with other NHS providers such as the Royal Brompton and Harefield NHS Foundation Trust. We will also be opening the Chelsea Children's Hospital in 2014 that will house paediatric services in state-of-the-art facilities that match the excellent service we already provide to children and families.

We remain focused on achieving our operational service goals. National clinical targets provide us with a benchmark of standards to meet that will ensure that patients get a high standard of NHS care in a safe and timely manner. Our year-end results show that we

have met all performance targets set by Monitor in 2012/13, we achieved 99% of overall targets set as part of the local Commissioning for Quality and Innovation (CQUIN) payment framework and are pleased to announce that nearly 99% of patients visiting A&E were seen and treated in four hours or less, which is the best record in the UK.

Our strong clinical performance is underpinned by an excellent financial record. The final year-end position is a surplus of £13 million, £400k better than planned against the 2012/13 financial target of a £12.6 million surplus. Cost Improvement Programmes (CIPs) were fully achieved for 2012/13.

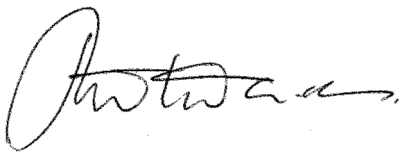
The Dr Foster Hospital Guide has named us as among the top five hospitals in England for lower than expected mortality rates. This means that we are saving the lives of patients that are most at risk of dying and we are delighted that the excellent standards of care our clinical teams provide has meant fewer deaths than expected of a hospital both of our size and of the complexity of conditions we see and treat.

There are always areas to improve and in 2013/14 we will focus on the flow and efficiency of our outpatients service, reviewing surgical pathways to ensure a timely service for patients and a renewed focus on continuing to improve the patient experience across all specialties.

This report sets out our achievements and challenges in some detail and is mainly aimed at our regulators and the wider NHS. It includes a director's commentary, a quality report, a governance statement and a finance report. We are also publishing a shorter, patient focused summary of the main points included in this document.

We hope that you enjoy reading the report, which gives you a flavour of our performance over the past year and the developments we have made to improve the quality, safety and efficiency of the healthcare services we provide.

Tony Bell OBE
Chief Executive



Professor Sir Christopher Edwards
Chairman

Our values

Shaping who we are and what we do

Chelsea and Westminster works to four key values in everything it does, which have been developed jointly with staff, patients and the wider public. This is so that patients know what to expect when they are cared for and staff know what is expected of them in terms of how we treat patients and each other as colleagues. Every member of staff is expected to embody these values in whatever they do. And, by doing this, it will translate to excellent care and experience for our patients.

Following discussions with staff, patients and our governors, the values were agreed at Board of Directors meeting in March 2012 and these are:

- **Safe**—"I will do everything I can to make our hospital as safe as possible for patients, relatives, carers and staff"
- **Kind**—"I will notice when you need help and go the extra mile"
- **Excellent**—"I aspire to be the best in all my actions and interactions"
- **Respectful**—"I will treat people as I wish to be treated myself"

We have spent 2012/13 embedding these values into everyday life at the hospital so that we are delivering care with these in mind, every time. Here are some examples of how we are living by our values to deliver excellent clinical services to patients:

Paediatrics

The paediatric team have written up their priorities under each of the values and these are reinforced and discussed at each shift handover. These include practical applications such as informing children and their parents 'who is looking after you for the day'. The team feel it is important that they all use the same language and understand what the values mean.

They have introduced a sticker system so that staff, patients and visitors could recommend a member of staff to receive a coloured sticker to put on their badge. Each colour of sticker relates to a value. This has generated a lot of discussion as staff discuss how and why they were awarded a sticker.

In 2013/14 the paediatric team are planning to have a values theme of the month to focus on what matters to patients.

Radiology

The radiology team used part of their training programme to discuss the Trust values and behaviours and what they can do to improve the patient experience. Each of the values was discussed in detail with three priorities identified. These priorities have been developed into a patient charter that is displayed in the department so that both patients and staff understand what to expect.

This has led to tangible changes to improve the dignity of patients including a separate waiting area for patients being transferred on a bed, protecting their privacy and dignity while they are transferred to another part of the hospital.

Maternity

The maternity team have held a competition for people to nominate a member of staff who most represents each of the Trust values. The winners are congratulated and the reasons why they were nominated are shared.

The team have also developed ward boards where the values and patient feedback is noted and plans to improve and respond to feedback are publicly shared. This *'You said—We did'* approach is being adopted by other wards and departments.

HR

As part of our ongoing programme of policy review we have included the Trust values into staffing policies. We have included the values into the whole recruitment process such as job descriptions, job adverts, interview questions and assessment centre exercises.

The values are included in both medical and non-medical appraisals and are part of our corporate induction programmes.

We will continue to embed our values into everyday life at Chelsea and Westminster in 2013/14. Progress against how we will continue to live by our values will be detailed in the next Annual Report.

About Chelsea and Westminster Hospital

Chelsea and Westminster Hospital NHS Foundation Trust provides healthcare services in the heart of central London. It became a Foundation Trust in October 2006 and has a sound financial record, achieving a surplus of £13 million in 2012/13.

The Trust has one hospital site with over 3,000 staff treating more than 360,000 patients every year. Our services include a full range of inpatient, day care and outpatients services. There is a strong focus on bringing NHS care out of the hospital setting and into the community including innovative sexual health services based at Dean Street Soho and the Charing Cross Hospital site. We contract ISS Mediclean, Norland and Health and Transport Services Ltd to provide catering, cleaning, estates and patient transport support on behalf of the Trust.

There is a strong focus on research and Chelsea and Westminster is a campus of Imperial College London School of Medicine. The Trust is one of the founding members of Imperial College Healthcare Partners, which is an organisation that has been set up to improve the health and social care of the population of North West London across all providers through shared working and innovation.

We have a large A&E service with approximately 300 visits each day. This number will increase once the *Shaping a healthier future* consultation changes are implemented. There is also a co-located paediatric A&E service providing specialist 24/7 expertise in the emergency treatment of children.

We provide a range of specialist services including paediatric and neonatal surgery, HIV and sexual health, maternity care for women with high risk complications, the treatment of adults and children with burns and bariatric weight-loss surgery. We provide specialist care to people from London, the South East and beyond.

We are delighted to have the support of many charities. Fundraising activities in 2012/13 have included helping the hospital purchase the UK's first surgical robot to be used solely for children's surgery at a cost of over £1 million.

This robot—named Pluto—will allow surgeons to perform more intricate surgery on babies and children with greater precision, quicker recovery times and smaller scars. Robotic surgery is much less invasive than traditional surgery, which will help early recovery and shorter hospital stays for patients. This is one of a range of investments in children's services, culminating in the opening of the Chelsea Children's Hospital in 2014.

Chelsea and Westminster patient numbers

- 112,000 A&E attendances
- 77,100 inpatient admissions (elective and emergency)
- 33,400 day cases
- 5,800 births (5,200 NHS patients)
- 527,800 outpatient consultations, plus 121,700 for HIV/sexual health services totalling 649,500 (this includes physiotherapy, direct access radiology and phlebotomy attendances)

Foundation Trust

Being a Foundation Trust

Giving staff, patients and members of the local community a greater say in how their hospitals are run is the driving force behind the creation of NHS Foundation Trusts. Greater involvement will bring lasting improvements to patient services and better health for the communities that we serve.

Being a Foundation Trust means that, while we remain firmly part of the NHS, we have been set free from central Government control to manage our own budgets and shape the services we provide to better reflect the needs and priorities of our patient base.

Any financial surplus we make we are able to reinvest into our own organisation to improve future patient care. However, this also means that it is our responsibility to ensure financial sustainability as the wider NHS will not provide emergency funding when things are not going well.

Through our Council of Governors we are able to listen to the views of patients, local people, staff and partners and by doing so offer patients faster, better and more responsive healthcare. Governors are chosen from our membership base and the most recent election was in November 2012.

You can be a member if you are over 16 years of age and are:

- A patient who has been treated at Chelsea and Westminster Hospital in the last three years or the carer of a patient who has been treated at Chelsea and Westminster Hospital in the last three years

- A member of the public living in the Royal Borough of Kensington & Chelsea, The City of Westminster, the London Borough of Hammersmith & Fulham or the London Borough of Wandsworth

- A member of staff (staff automatically become members when starting employment with the Trust unless they 'opt out')

- A volunteer at Chelsea and Westminster Hospital

At the start of 2012/13 there were 14,858 members and at the start of 2013/14 there were 15,268 members. This shows a gain of 410 members. At the start of 2013/14 the overall membership includes 5,850 public members, 5,994 patient members and 3,424 staff members.

The Membership Strategy for 2012/13 outlined the need for more focused membership engagement. It also addressed the need to increase membership with black and minority ethnic (BME) groups. During the year, the Trust implemented an enhanced membership programme of activity thanks to funding from the Council of Governors, where extra members events took place and had a positive impact on engagement. This programme included:

- 3 *Trust News* membership mailings
- 12 *Members' News* monthly membership email newsletters
- 5 'Medicine for Members' seminars
- Open Day
- Annual Members' Meeting
- Christmas event

Analysis of the membership database by age, gender and ethnicity is undertaken to help the Trust work towards developing a membership that is representative of the communities we serve.

The members' events were promoted to the Black and Minority Ethnic (BME) Health Forum with good representation from its members. This prompted us to deliver a special 'Medicine for Members' event focused on diabetes, which has an increased prevalence in people of Black African descent.

Other targeted activities have included the recruitment of new members from a Somali women's group at West London Centre for Sexual Health in March 2012 and the recruitment of new members at regular Shepherd's Bush Market mobile community health clinic sessions.

The Trust also involved members in campaigns to seek feedback on key issues. These included the 'Who do you think WE are?' consultation on the Trust's values in February 2012 and the 'Show us the way' consultation on proposed improvements to wayfinding in the hospital.

In May 2012 the Trust Board approved a Communications & Engagement Plan for the *Shaping a healthier future* public consultation about proposed changes to NHS services in North West London. Chelsea and Westminster Hospital received strong support from its members.

While the Trust has been successful with membership engagement it is equally important to maintain its membership numbers. There is a large movement of members leaving the Trust—in 2012/13 there were 1,811 new members while 1,401 left membership. It is therefore necessary to be active with membership recruitment to maintain the current figures. We commission Capita Recruitment to recruit an agreed target of new members. The recruiters also actively engage with the new members to promote activities such as governor elections and the Open Day.

Meet a Governor

Members of Chelsea and Westminster Hospital have the opportunity to meet their elected representative on the Council of Governors at regular 'Meet a Governor' sessions which are held in the Information Zone on the Ground Floor of the hospital (near Costa Coffee).

'Meet a Governor' offers an opportunity to come along for an informal chat or to give feedback on hospital services or treatment received.

These sessions are communicated to members in advance through the *Trust News* membership mailings, the monthly *Members' News* email newsletters, and via the 'Get Involved' section of the Trust website.

We want to increase our membership to ensure it remains representative of the range of communities we serve. Becoming a member will give you the opportunity to be involved with your hospital and take an active part in helping to shape our future as an organisation. It also gives you an opportunity to become a Governor and have a more formal leadership role at the hospital.

If you'd like to join the Chelsea and Westminster membership team please contact the Foundation Trust Secretary on 020 3315 6716 or ftsecretary@chelwest.nhs.uk.

2012/13 in highlights

- **April 2012:** The Trust's four new values were formally launched across the organisation and to external stakeholders, providing staff and patients with a set of standards which we and they should expect from Chelsea and Westminster.

- **May 2012:** Chelsea and Westminster was singled out by the Department of Health as one of just 59 acute Trusts in the country that have no patients waiting for more than 12 months for hospital treatment.

- **June 2012:** Imperial College Healthcare Partners launches with Chelsea and Westminster as one of the founding partners. The partnership has been set up to improve the health and social care of the population in North West London. The Trust is currently hosting the partnership, which is waiting to be named as one of the national Academic Health Science Networks in spring 2013.

- **July 2012:** The All Party Parliamentary Group on Maternity announced two awards for the Trust's female genital mutilation service. The Trust was also working hard to minimise disruption to staff and patients as a result of London 2012 Olympics and it was business as usual at Chelsea and Westminster Hospital during the Olympic cycling road race even though road access to the hospital was severely restricted throughout the weekend.

- **August 2012:** Patient and public governors launched a campaign to petition to keep a full A&E service at the hospital following the launch of the *Shaping a healthier future* consultation to centralise the number of major A&E services to five across North West London.

- **September 2012:** A joint study with the Royal Marsden Hospital showed that cancer patients with diabetes need access to specialist diabetic care while undergoing treatment in order to improve their chances of survival.

- **October 2012:** The Intensive Care Unit was nominated for a Health Service Journal award in the Emergency and Critical Care category.

- **November 2012:** The results of the *Shaping a healthier future* consultation recommended Option A, which would see Chelsea and Westminster Hospital retaining a full A&E service.

- **December 2012:** 56 Dean Street, in conjunction with The Gay UK, launched an online clinic that helps people to get sexual health advice confidentially. They also broke their own world HIV testing record to help mark World AIDS Day.

- **January 2013:** A purpose-built Children's Burns Unit—Mars—opened on the 1st Floor with six beds, an assessment room, therapy room and a dressing clinic funded by the London Specialised Commissioning Group (SCG). The London SCG also approved £2.4 million of funding for the redevelopment of the adult burns service, which will be completed by the end of 2013.

- **February 2013:** Miss Zoë Penn (Consultant in Obstetrics and Gynaecology) was appointed as new Medical Director for the Trust replacing Consultant Gastroenterologist Dr Mike Anderson who had been Medical Director since 2003.

- **March 2013:** Chelsea and Westminster was named among the top 20% best rated Trusts in the country for effective communication with staff in the 2012 staff survey results. We also opened a brand new Diagnostics Centre with investment of £3 million.

STRATEGIC PRIORITIES AND PERFORMANCE

Introduction

The Trust's strategic vision for 2012/13 was "to deliver safe and sustainable care of the highest quality and to be the provider of choice for our local population and those using specialist services, provided in a modern way by multi-disciplinary teams working in an excellent environment, supported by state-of-the-art technology and world-class academic research."

To deliver this vision the Trust had three strategic objectives for 2012/13. Our progress against each objective is outlined below.

Maintaining and developing our key clinical specialties

We have engaged fully in the *Shaping a healthier future* public consultation on service reconfiguration in North West London and developed a strong response to the consultation, asking staff members and the public to support Option A which would ensure that Chelsea and Westminster retains a full A&E service.

There are numerous developments happening around clinical services delivered on a regional basis and we have been fully involved in discussions to review cancer networks, work to centralise HIV services and the burns facility designation process. Those who commission burns services on a regional level have supported the development of adult burns services on the Chelsea and Westminster Hospital site. We are currently having discussions to look at the role that the new Chelsea Children's Hospital will have in tertiary children's services in North West London.

A new Diagnostic Centre opened on the main hospital site in February 2013, providing state-of-the-art equipment to support the accurate and timely diagnosis of conditions and enables the Trust to accommodate the anticipated further growth in demand for endoscopy services.

Please refer to the Quality Report section for more detail about our improvements.

Exploring opportunities for growth

The Trust has successfully applied as part of Imperial College Healthcare Partners to become an Academic Health Science Network, with a Chief Executive recruited and a detailed work programme in progress.

We are also looking at opportunities to expand private patient services at the hospital. Any profits made will be re-invested into ongoing NHS services.

We are looking to respond to all regional and national tenders where health services will be provided over a larger geographical area. In 2012/13 we won the contract to provide musculoskeletal services across Kensington and Chelsea and in 2013/14 we will consider bidding to provide sexual health and dermatology services in Hounslow.

Ensuring sustainability

We have worked hard to embed our values across the organisation through the 'It's Who We Are' project to improve the patient and staff experience. The values, agreed with staff and the Trust Board, have been sent to all teams and departments who are identifying behaviours which are being reviewed by the Patient and Staff Experience Committee.

Our Trust values are being incorporated into all planning work for the organisation including the quality planning process, and are being incorporated into appraisals and the recruitment process. Work is ongoing in 2013/14 to embed them into all other areas of the organisation. This work is detailed in the values section of the report.

We are looking to reduce unnecessary corporate costs so our funds can be focussed on direct patient care and we have appointed a joint Procurement Director with the Royal Marsden Hospital NHS Foundation Trust who will be responsible for purchasing goods and services that are value for money for the taxpayer. Part of this role is also to look at all back office functions at the hospital and other opportunities for partnership.

Our physical environment is being reviewed in relation to the *Shaping a healthier future* consultation, sharing some paediatric care with the Royal Brompton and Harefield NHS Foundation Trust and potential partnership working with the West Middlesex University Hospital NHS Trust. Work is ongoing with these projects and will be an area of focus for the Trust in the coming year, which we will report on in the 2013/14 Annual Report.

Our corporate objectives

Corporate objective 1: Improve patient safety and clinical effectiveness

- Chelsea and Westminster was named as one of only five hospitals in England with lower than expected mortality rates for three of the four mortality indicators measured in the Dr Foster Hospital Guide.

- We were the best performing A&E Department in the country for the national four hour target.

- For 2012/13, we set ourselves a target of 25% fewer hospital associated VTEs meaning no more than 13 hospital associated preventable VTEs. In 2012/13 we identified 13 hospital associated preventable VTEs and achieved our target. We will focus on addressing the contributory factors for preventable VTEs in 2013/14.

- The House of Commons presented the hospital with the national Lifeblood VTE award 2012 for ‘Best Obstetrics VTE Prevention Programme’, in recognition of its exemplary leadership and dedication for innovative initiatives to help reduce VTE among pregnant women.

- We met Monitor performance targets for MRSA bacteraemia and *C.difficile.*

Please refer to the Quality Report section for more detail about our improvements in patient safety and clinical effectiveness.

Corporate objective 2: Improve the patient experience

- During 2012/13 complaints relating to attitude of staff have been reported to the Patient and Staff Experience Committee. In response to the issues identified, each division has developed action plans to improve the patient experience relating to each of the themes. These are reviewed and updated on a bi-monthly basis. The key achievements are reported to the Patient and Staff Experience Committee.

- We have introduced ‘comfort rounds’ where all inpatients are asked by a nurse on their ward every two hours or less whether they need any support or assistance.

- We updated our Patient Information Policy in September 2012 to reflect an audit of the information we provide to patients and how this could improve.

- We have consistently performed well against the Friends and Family Test monthly monitoring and have had no single sex accommodation breaches.

- We initiated our quality campaign to ensure that our staff are working to our values of being ‘safe’, ‘kind’, ‘excellent’ and ‘respectful’.

Corporate objective 3: Deliver excellence in teaching and research

- In 2012/13 the number of patients recruited to take part in research that had been approved by a research ethics committee was 1,999. The Trust was actively involved in 281 clinical research studies, 149 of which were part of the National Institute for Health Research (NIHR) portfolio. This is a collection of high quality national studies covering a broad range of clinical areas such as cancer, stroke and paediatrics.

- The Trust collaborated with various research partners to make sure that its research work is responsive to national and local priorities. They include NIHR research networks and local charities such as Westminster Medical School Research Trust and Chelsea and Westminster Health Charity. We also host the NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for North West London, which aims to apply new treatments and approaches to clinical care in the NHS.

- Imperial College Healthcare Partners launched with Chelsea and Westminster as one of the founding partners. The partnership has been set up to improve the health and social care of the population in North West London. The Trust is currently hosting the partnership, which is waiting to be named as one of the national Academic Health Science Networks in spring 2013.

- Early 2013 has seen a consultation on how the structure of our Learning and Development team can be aligned to ensure that our workforce has the right skills and capabilities to support the delivery of excellent care and drive continuous improvement to sustain high quality outcomes for all of our patients.

Please refer to the Quality Report section of this document for more information about excellence in teaching and research.

Corporate objective 4: Ensure financial and environment sustainability

- In 2012/13 we achieved a financial risk rating of 5, a better performance than our plan which was to achieve a rating of 4.

- We were £400k ahead of our surplus plan for the year.

- We achieved 100% of our CIPs equating to £16.2 million.

- The Trust has continued its multi-million pound investment programme to maintain and improve its facilities and meet rising demand for services. Further information on these works is detailed on page 68.

QUALITY REPORT

About this report

What is a Quality Report?

All providers of NHS services in England have a statutory duty to produce an annual report to the public about the quality of services they deliver. This is called the Quality Report.

Quality Reports aim to increase public accountability and drive quality improvement within NHS organisations. They do this by getting organisations to review their performance over the previous year, identify areas for improvement and publish that information along with a commitment to you about how those improvements will be made and monitored over the next year. In the report 'year' refers to the period April 2012 to March 2013 (2012/13).

Quality consists of three areas, which are important when delivering high quality services:

- Patient safety
- How successful is the care provided (clinical effectiveness)
- How patients experience the care they receive (patient experience)

Some of the information provided in a Quality Report is mandatory, but most of the content is decided largely by what parents and carers, Foundation Trust governors, staff, commissioners$_{G}$, regulators, and our partner organisations (collectively known as our stakeholders) ask us to cover.

Note: '$_{G}$' denotes items explained in glossary

Scope and structure of the Quality Report

This report summarises how well Chelsea and Westminster Hospital NHS Foundation Trust did against the quality priorities and goals we set ourselves for 2012/13. It also sets out those we have agreed for 2013/14, and how we intend to achieve them.

We asked patients, their relatives and friends, other service users and staff for their views on our annual quality report to inform future style and content. In March 2011, experienced researchers asked staff and visitors in the public areas of the hospital what they thought about the 2010/11 report, and in November 2012, what they thought about the 2011/12 report.

More than 50 surveys were completed on each occasion. The results showed that the 2011/12 Quality Report was seen as a significant improvement on the previous year's report. Last year 36 people found the report attractive compared with 15 the previous year, while 62 thought the presentation of the material had improved—up from 42 the previous year. 57 respondents approved of the content and quality of information compared with 38 the previous year. And 61 felt the quality of the writing was good in 2012 compared with 34 in 2011.

We have restructured the report so that wherever possible, we have incorporated the feedback into the look and feel of this year's report while still fulfilling the statutory obligations required of us by the Department of Health (DH) and our regulator, Monitor$_{G}$.

This report is divided into five parts:

Part 1 includes a statement from the Chief Executive and looks at our performance in 2012/13 against the priorities and goals we set for patient safety, clinical effectiveness and patient experience. If we have not achieved what we set out to do we explain why and outline how we intend to address these areas for improvement.

Part 2 sets out the quality priorities and goals for 2013/14 and explains how we decided on them, how we intend to meet them and how we will track our progress.

Part 3 sets out how we identify our own additional priorities for improvement and provides examples of how we have improved services for patients, including our research work.

Part 4 summarises our performance against national priorities and our local indicators (those we have developed within the Trust) in tabular form.

Part 5 describes how we review and evaluate the quality of the services we provide, including information and data quality. It also includes a description of audits we have undertaken and how our staff contribute to quality.

The annexes at the end of the report include the comments of our external stakeholders and provide supplementary information including:

Annex 1: Statement of Directors' responsibilities in respect of the Quality Report

Annex 2: Independent Auditor's Assurance Limited Report to the Council of Governors of Chelsea and Westminster Hospital NHS Foundation Trust on the Annual Quality Report

Annex 3: Statements from key stakeholders:

- Council of Governors response to Chelsea and Westminster Hospital NHS Foundation Trust Quality Report 2012/13

- Healthwatch Central West London$_{G}$ response to Chelsea and Westminster Hospital NHS Foundation Trust Quality Report 2012/13

- The Central London, West London, Hammersmith and Fulham and Hounslow (CWHH) Clinical Commissioning Groups Collaborative statement in response to Chelsea and Westminster Hospital NHS Foundation Trust Quality Report 2012/13

- The Royal Borough of Kensington and Chelsea's Health, Environmental Health, and Adult Social Care Scrutiny Committee and Westminster City Council Adult Services and Health Policy Scrutiny Committee

Annex 4: Response to Statements

Annex 5: Glossary of terms used

Annex 6: Trust Committee structure and clinical divisional structure including the various committees and steering groups referred to throughout this report.

If you or someone you know needs help understanding this report or you would like a printed copy or would like the information in another format such as large print, easy read,

audio or Braille, or in another language, please contact the Director of Nursing and Quality by calling 020 3315 6599 or by emailing quality@chelwest.nhs.uk.

About the Trust

The Trust is a modern, purpose-built hospital with more than 3,000 staff. It has three clinical divisions which are outlined in more detail in Annex 6.

Chelsea and Westminster Hospital NHS Foundation Trust provides general and specialist services for half a million people living in the four local boroughs of Kensington and Chelsea, Westminster, Hammersmith and Fulham and Wandsworth. The Trust also provides specialist tertiary[G] services to patients from a wider area in a range of specialties. These include bariatric surgery, burns, HIV, paediatrics, neonatal care, orthopaedics—foot and ankle and sports injuries (eg knee conditions including multiligament instability) and plastics—craniofacial surgery, complex wrist and hands

Most services are provided on the Chelsea and Westminster Hospital site but the Trust also runs a highly successful network of community HIV and sexual health centres, dermatology clinics, community musculoskeletal therapy and community maternity services across our four local boroughs. Additionally we provide women's reproductive health (gynaecology) services in Richmond and Twickenham.

The hospital has the busiest and most extensive HIV[G] and sexual health service in Europe based in three different centres across the capital.

Chelsea Children's Hospital, officially opening in 2014, is a key part of the Trust. Nearly 12,000 children were admitted last year. The Trust also has a dedicated children's A&E[G] department and a High Dependency Unit[G].

Pregnant women at high risk of complications are cared for in the Trust's Maternity Unit, while the Neonatal Intensive Care Unit provides specialist services for newborns.

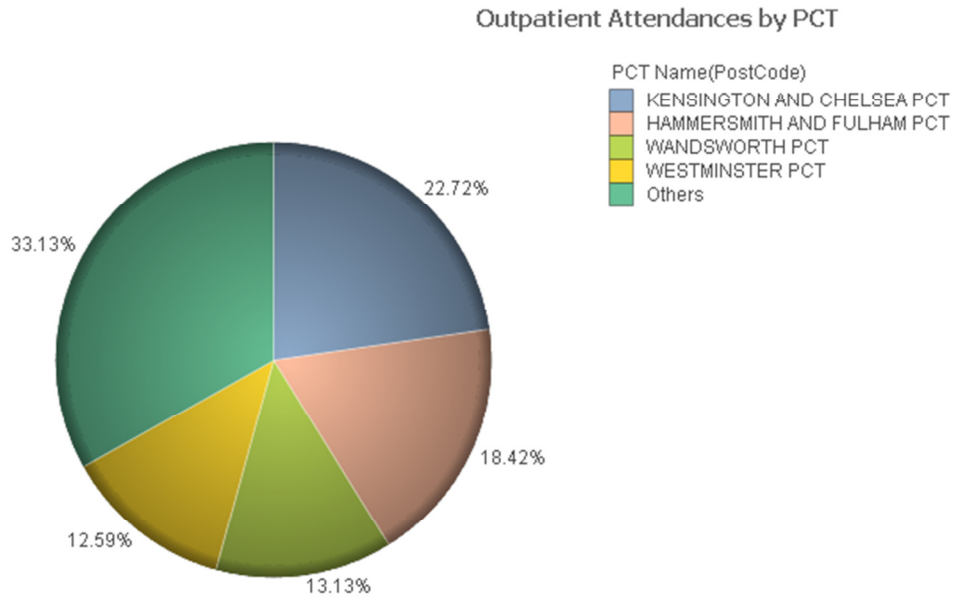
The Trust is one of two centres providing weight loss surgery services for London and the South East. It is also the Regional Burns Centre for London for adults and children. A separate unit for children was newly commissioned in January 2013 which has greatly enhanced our children's burns care. Overall, around 450 burns patients were admitted in 2012/13.

Last year there were approximately:

- 112,000 A&E attendances
- 77,100 inpatient admissions (elective[G] and emergency)
- 33,400 day cases
- 5,800 births (5,200 NHS patients)
- 527,800 outpatient consultations, plus 121,700 for HIV/sexual health services totalling 649,500 (this includes physiotherapy, direct access radiology and phlebotomy attendances)

A key part of the service we provide for our patients is our busy outpatient service. The diagram below highlights the main Primary Care Trusts (PCTs) from which we receive our patients as described up to end March 2012. From 1 Apr 2013 PCTs were replaced by

new organisations called Clinical Commissioning Groups[G] as part of the changes in the NHS outlined in the Health and Social Care Act 2012.



Part 1

Statement on quality from the Chief Executive

Patient experience and patient care are at the very heart of what we do at Chelsea and Westminster and what we should be judged by.

This report is a snapshot of where we are in a particular year. But just as important is the quality of what we do for patients day by day, year by year, restlessly and relentlessly.

We need to do more than focus on just meeting immediate targets; an above average performance may still mean care is nowhere near good enough in terms of the outcome or experience of individual patients. We always want to do better for every patient wherever we can and we are never satisfied or complacent just because a target is met.

Some of the highlights I would like to draw attention to include: the Care Quality Commission (CQC)conducted an unannounced inspection on three wards in July 2012 and found we met all five standards assessed; the Dr Foster Hospital Guide named us as among the top five hospitals in England for lower than expected mortality rates and we have received awards for our female genital mutilation service and the national Lifeblood VTE award 2012 for 'Best Obstetrics VTE Prevention Programme'.

This year we initiated our quality campaign—you can read more about it on page 41. Quality is about patients and staff and our four values of 'safe', 'kind', 'excellent' and 'respectful' are a fundamental part of that. We have been reviewing our approach toward quality improvement and focusing on what patients, families and staff are saying. All too often it's not the high standard of clinical outcomes we achieve that is the problem—we tend to do well in these areas. Where we need to improve is in providing a better experience for our patients in our communications, clinical management systems and information. As with all our experiences in life it's the little things that make a big difference to us. These are the areas where we need to pay attention as we continue our quality

journey. Our values are the foundation for how we will deliver on these improvements over the coming year. Embedding these values will translate into excellent patient care and experience for the populations that we serve.

I would like to take this opportunity to thank our dedicated team who have all worked so hard to deliver the highest standards of quality to our patients. We have achieved a lot in which we can take great pride. We recognise that there is still much to do and I know that from the ward to the Trust Board there is a great sense of commitment toward our aspiration for excellence.

To the best of my knowledge, the information in this Quality Report is accurate.

Tony Bell OBE
Chief Executive
28 May 2013

Our Quality Report Card

What our stakeholders told us

We have an ongoing process of listening to patients and governors and external stakeholders such as Kensington and Chelsea Local Involvement Network$_G$ (now replaced by Healthwatch Central West London) and regularly review feedback from patients through complaints and quarterly surveys. This is described in more detail in the patient experience section on page 26.

This Quality Report Card provides a sample of how we are performing. Please see the full report for further information.

Safety	
Where we did well	**Where we could do better**
Met our target for reduction in numbers of patients with preventable VTE—13 (see page 24)	VTE incidence—continue objective to reduce further and ultimately to zero (see page 32)
Met our target for a reduction in MRSA—only 1 case and *C.Difficile*—halved the number of patients with *C.Difficile* to 15 (see pages 70 and 73)	Never events—we had three this year and our target is zero (see page 44)
Low patient falls rate (see page 42)	Timeliness in reporting serious incidents (see page 44)
Initiatives for medication safety eg medicines passport (see page 53)	
Effectiveness	
Where we did well	**Where we could do better**
Met our target of 75% of emergency general medical and surgical patients to be seen by a consultant within 12 hours of the decision to admit to hospital or within 14 hours of their arrival at the hospital (see page 30)	Compliance with care bundles for central lines and peripheral lines—did not meet our targets (see page 73)
Lower than average mortality as measured by mortality indicators—HSMR and SHMI (see page 71)	Pressure ulcers—we wish to see the numbers much reduced (see page 46)

Patient experience	
Where we did well	**Where we could do better**
Assessing quality of care by observing care on the wards eg clinical rounds—involved governors and senior staff (see page 33)	Our patients are telling us that there is room for improvement in how we communicate and in the discharge process (see page 26)
Improvements for patients with dementia eg the refurbishment of one of our wards to be 'dementia friendly' (see page 28)	Attitude and behaviour of staff is one of the 3 highest types of complaints (see page 48)
Volunteer service eg help with feeding (see pages 28, 37, 49, 56)	Appraisal rate of staff improved to 82% but we did not reach our target of 87% (see page 29)
Created the Butterfly Room to provide a peaceful non-medical environment for patients in the last days and hours of their lives (see page 39)	

Our priorities for quality improvement 2012/13

Priority 1: Patient Safety

To have no hospital associated preventable venous thromboembolism (VTE)

VTE is an umbrella term for potentially serious blood clots called deep vein thrombosis (DVT) and pulmonary embolism (PE). A DVT usually develops in the leg or pelvis. Sometimes part of the blood clot breaks off and ends up in the lung (PE) where it can block the blood supply. This can be fatal.

The risk of developing VTE is heightened after surgery and/or periods of immobility, and in certain conditions such as pregnancy or advanced cancer. Around half of all cases arise in patients who have recently been in hospital. Around one third of patients will develop VTE despite the best care but in the remaining two-thirds of patients a VTE can be avoided with preventive treatment.

We have made improvements but have not yet achieved our target and so have kept this as a priority for 2013/14.

What we said we would do in and what we actually did in 2012/13

VTE risk assessments
All adult patients should have a VTE risk assessment completed on admission to hospital to identify any risk factors that may be present.

We said we would continue to ensure that we meet our target of 90% adult patients admitted with completed VTE risk assessments. Our weekly and monthly monitoring of completed VTE risk assessments showed that we achieved this target.

Patient information
If patients are informed about the risks of VTE, and its signs and symptoms, they will know when to seek urgent medical attention.

We said we would continue to offer our patient information leaflet '*Are you at risk of blood clots?'* to all patients admitted to the hospital, all pregnant women and all patients attending A&E who require a lower limb plaster cast.

Our monthly audits confirmed the VTE patient information leaflets were available and visible on all adult wards.

We were unable to measure on a regular basis whether inpatients were offered the VTE patient information leaflet as there was no systematic recording of whether information leaflets were given. Following other successful areas of practice, we have added VTE patient information to the hospital's admission and discharge checklist to ensure patients receive the leaflet.

VTE patient information has been included in the maternity patient-held notes for pregnant women and it is recorded in the booking notes when patients are offered our '*Are you at risk of blood clots in pregnancy?'* information leaflet. An audit throughout the year showed 96% of women on the maternity wards received the VTE patient information leaflet and this is recorded.

An audit on one day in February 2013 showed that all 20 patients undergoing day case procedures in the Treatment Centre were offered the VTE leaflet. A similar audit between April and June 2012 showed that only 69% of patients with leg plaster casts were given an information leaflet in A&E and the Urgent Care Centre.

As a result, surgeons and emergency care staff were updated on the importance of providing VTE information to patients and this message was included in the VTE newsletter circulated to all staff. The VTE risk assessment document which helps determine whether preventive treatment is required was updated to highlight VTE patient information more clearly.

Preventive treatment
We said that adult patients at risk of VTE will receive appropriate preventive medication and the use of compression stockings, if indicated, to help prevent blood clots developing during hospital admission. We set a target of 90% of adult patients to receive appropriate medication and compression stockings.

During 2012/13 we performed monthly audits and on average over 90% of adult patients received appropriate preventive medication, in line with the target we had set, but only 79% of adult patients received compression stockings.

When we explored the reasons for this we discovered that there was some confusion about who was responsible for prescribing compression stockings. After discussions with a wide range of staff it was agreed that doctors in all specialties should take on that responsibility, except in areas where nurses or midwives were specifically trained. Nurses and pharmacists will encourage doctors to prescribe compression stockings, provided there are no reasons why it might be harmful to do so. A monitoring form for compression stockings was developed to make sure they are fitted properly and patients were monitored daily to inspect skin condition.

VTE training
We said we would create an online training module on VTE prevention and treatment for all doctors working in the hospital to complement the training modules we already have for nurses. We wanted to make sure that all frontline staff are aware of the preventive treatments we use in this hospital and standardise training.

The VTE module is now available on the training database and the focus next year will be on increasing uptake of completion for all doctors working in the hospital.

But most importantly...
Our goal is to have no hospital associated preventable VTEs by ensuring VTE risk assessments are completed, preventive treatment is prescribed, patients are educated and nurses and doctors are trained in VTE prevention.

We said that we would continue to undertake a thorough review (root cause analysis or RCA) of cases where patients with preventable VTE associated with a hospital admission, defined as during or within 90 days of admission, did not receive appropriate preventive treatment.

For 2012/13, we set ourselves a target of 25% fewer hospital associated VTEs than in the previous year — ie to have no more than 13 hospital associated preventable VTEs. Between April 2012 and March 2013, we have identified 13 hospital associated preventable VTEs. While we achieved our target for 2012/13 this is still too many and we will focus on addressing the contributory factors for preventable VTEs in 2013/14.

And finally...
The House of Commons presented the hospital with the national Lifeblood VTE award 2012 for 'Best Obstetrics VTE Prevention Programme,' in recognition of its exemplary leadership and dedication for innovative initiatives to help reduce VTE among pregnant women.

We were also selected to present our collaborative work on VTE prevention across all specialities at the International Forum on Quality and Safety in Healthcare 2013.

Priority 2: Patient Experience

Focus on three key areas: communication, discharge planning and the care of older people

Nothing matters more for us than patient outcomes (was our care safe and effective?) and patient experience (is the patient experience central to everything that we do?)

We said that we would communicate the agreed Trust values of being safe, kind, excellent and respectful, and the related behaviours to staff, patients and their families as well as our other stakeholders. This is to let everyone know what is expected of them and help drive improvements in the key areas of communication, discharge planning and care of the older person. And we said that we would ensure that the Trust values informed everything that we do.

What we said we would do in 2012/13

Communication
- Improve the content, presentation and timeliness of appointment letters

- Produce information on ward routines for all adult inpatients which will be laminated and attached to each bedside locker

Discharge planning
- Aim to improve the co-ordination of discharge with primary and community care teams and so reduce the length of stay and readmissions for patients with complex needs

- Continue to look at setting up consultations with a clinical senior member of staff immediately before discharge, and following up the next day by phone

Care of the older person

- Roll out comfort$_{G}$ rounds to all adult inpatient areas

- Continue to monitor our performance against the CQC$_{G}$ essential standards of quality and safety$_{G}$ relating to privacy and dignity through the senior nursing and midwifery clinical rounds

- Continue monthly audits of nutritional screening and continue to develop other measures to ensure our patients are well fed eg volunteer mealtime support

- Continue to provide training in dementia$_{G}$ for nurses, therapists and doctors—this objective is linked to a CQUIN$_{G}$ payment

What we actually did

- We launched the Trust values at our Open Day in May 2012

- A summary of Trust values and behaviours was published in October in *Trust News*$_{G}$

- Individual teams and departments have been developing their own priorities associated with these values and behaviours.

- At interview, we ensure job applicants understand that these values are expected of everyone who works at the Trust. They are included in all staff policies.

- We have agreed to site a 'patient experience board' in each patient area, which will display patients' feedback on how these values and behaviours are being put into practice.

Communication

Over 400 appointment letters have been reviewed to check that the information is current and that the correct templates for each service are being used. The wording used in letters is now being revised to ensure that it is clear, precise and service specific where relevant and we are involving patients in this.

From May 2013 we will pilot outsourcing outpatient letters. This should speed up the service and enable us to track progress from issue to delivery. If successful, individual letters will then be tailored to the specific specialty and include maps, directions and any other relevant information.

Information on ward routines has been developed for each of our adult inpatient wards, laminated copies of which are available for patients at their bedside.

Discharge planning

We have worked on overhauling the discharge process with our community and social service colleagues as part of a discharge transformation project. As a result we have introduced daily 'board rounds' where the multidisciplinary team discuss progress on preparations for the discharge of each patient.

We have also

- Shifted the emphasis to patients being assessed as fully ready to go home, for example, having the required support, rather than just being medically well enough to do so

- Appointed an End of Life Care Discharge Co-ordinator to help patients cope in their latter days

- Introduced an electronic discharge checklist for all members of the multidisciplinary team to use

- Begun work to implement nurse led discharge for patients

We tested out a phone survey with 10 patients about their experiences of the discharge process in October and November 2012. The survey asked about the advice and information given at discharge and if patients would recommend the hospital to others. Following evaluation of the survey questions, phone surveys are now being used in children's areas and a version is being developed for those using day care facilities.

Care of the older person

'Comfort rounds' are now routine on all medical and surgical wards and will be implemented in other wards starting in May 2013.

The senior nursing and midwifery clinical rounds are up and running across the hospital and cover the 16 CQC standards. As a direct result we now have guidelines for intimate care and use 'red pegs' on curtained areas in wards to increase privacy.

We have updated our nutritional checklist for adult patients to make sure they are eating properly and introduced a similar one for children. Volunteers continue to provide mealtime assistance on relevant wards.

Three of our staff have been trained to deliver dementia training to their staff, primarily healthcare assistants and junior doctors, and have prioritised training to wards where patients with dementia are likely to be admitted.

The David Erskine Ward has been refurbished to be 'dementia friendly'G (see below), and a similar upgrade is planned for the Edgar Horne Ward.

How did we perform in 2012/13?

Every three months, we monitor and review complaints and concerns relating to communication, discharge planning, and the care of older people to see what further improvements we need to make.

This includes sending recently discharged patients a short survey about their experiences of the discharge process. These focus on key areas for improvement based on our previous years national patient survey findings. The survey results are reviewed at our Patient and Staff Experience Committee and Senior Operational Group with action plans drawn up.

Volunteers have been helping to monitor how well adapted our adult facilities are for patients with dementia and their carers by scoring each ward on defined criteria such as atmosphere, the physical environment and the types of activities provided.

Their audit of 7 wards and the Acute Assessment Unit showed that more needs to be done to improve the physical environment, including personalising bays and bed spaces, clearer signage, the addition of hand-rails, and the provision of larger social spaces.

Priority 3: Staff Experience

To be in the top 20% of acute Trusts nationally for staff engagement$_G$ and staff appraisals as measured by the NHS staff survey and to ensure our agreed Trust values inform everything that we do

Why do staff appraisals and engagement matter?

A growing body of evidence shows that, as one would expect, that there is a direct link between a satisfied and engaged workforce and the quality of care patients receive.

An appraisal provides both an individual and his/her supervisor with the opportunity to reflect on how well the individual has met agreed targets and objectives over the past year, to identify any training needs and areas for personal development and to review any issues or concerns that the staff member or supervisor may have.

We have made good progress on this priority but we did not achieve everything we set out to do so will be continuing to focus on our staff throughout 2013/14.

What we said we would do in 2012/13 and what we actually did

Celebrating staff achievements
We said we would hold the first Chelsea and Westminster Star Awards in May 2012 to recognise staff achievements. These attracted almost 800 nominations from patients and staff, and 20 staff and teams received an award.

Appraisals
We said we would increase staff appraisal rates to at least 87%. We didn't manage this, or achieve our goal of being in the top 20% for this part of the survey, but we did record our best record to date with 82% of staff appraised.

We said that we wanted to increase to 75% the percentage of staff appraised with a personal development as measured by the NHS staff survey which would put us in the top 20% of acute Trusts. The relevant question was removed from the NHS wide staff survey this year and development review was incorporated into the appraisal question above which achieved 82%. This meant that we did not achieve the target of being in the top 20% of acute Trusts for this measure.

We said we wanted to increase to at least 50% the percentage of staff reporting a well-structured appraisal, which is defined as one that helps an employee do their job better, highlights any training needs and makes them feel valued by the Trust. We achieved 45%, which was below our stated target, but it still means the Trust remains in the top 20% of acute Trusts nationally on this indicator.

Trust values
We said we would give every member of staff written confirmation of our Trust values by the end of June 2012. Every member of staff was given a folded colour leaflet, setting out

the Trust values, with their August 2012 payslip. We also ran events and discussion groups for staff about the values.

We said we would review all aspects of staffing policy including recruitment, appraisal and training in light of these values and amend practice accordingly. All new staff now receive a copy of the values in the information pack for new starters and these values are included in all job adverts, interview questions, job descriptions and person specifications as well as the *Staff Handbook*, which is published annually. The appraisal form was redesigned to include evidence of behaviours based on these values and the October issue of *Trust News* carried a pull-out poster that teams can use to develop their own priorities related to these values and behaviours.

The values and behaviours have also been included in the Corporate Induction Programme$_G$, the Excellence in Care Programme$_G$ for health care assistants and the development programme for staff nurses.

We said we would look for improvements in scores for the 16 questions in the national patient survey where we scored below average for our four key values of safe, kind, excellent and respectful. Six of these questions were not included in the 2012 national patient survey but of the remaining 10, 2 remained the same and 8 improved. We will use the responses from this survey to refocus efforts on our priorities and track progress.

Staff engagement
The NHS staff survey results published in March 2013 show that the Trust remains in the top 20% of acute Trusts nationally for staff engagement for the fourth year running—measured by questions relating to motivation, ability to contribute to improvements and willingness to recommend the Trust as a place to work or receive treatment.

Priority 4: Clinical Effectiveness

At least 75% of emergency general medical and surgical patients to be seen by a consultant within 12 hours of the decision to admit to hospital or within 14 hours of their arrival at the hospital

Why is this important?

In 2011/12 we were the only hospital in England with low mortality rates across all four mortality indicators in the Dr Foster Hospital Guide$_G$. However we recognise that there is more we can do to improve all aspects of patient care and safety.

Guidance from professional bodies shows that consultant-led care for emergency patients is critical to rapid decision-making about appropriate treatment, maintaining standards and improving the patient's care throughout their time in hospital. This is why we are committed to ensuring that emergency patients at our hospital are seen by a consultant within 12 hours of admission.

Feedback and analysis of complaints data show that involving consultants earlier in a patient's care can improve their satisfaction with, and confidence in, the care they receive. And our own figures show that we tend to discharge fewer patients at weekends which means we are not making the most efficient use of our staff and bed space.

What we actually did

Emergency general medical patients admitted to the Acute Admissions Unit (AAU) are reviewed by the on-call consultant on twice daily ward-rounds—in the morning and in the evening. This means that we have increased the number of medical patients that are seen by a consultant within 12 hours of their admission.

Emergency general surgical patients may be admitted to the AAU or to a more specialised surgical ward; regardless of their location, there are now twice daily ward rounds conducted by the on-call general surgeon to review these patients. This means that we have increased the number of emergency general surgery patients that are seen by a consultant within 12 hours of their admission.

While performance at the start of the year was monitored through retrospective paper-based audits which were highly resource-intensive, we are now using our IT system to identify when patients were seen, thus improving the timeliness and efficiency of the monitoring process.

How did we perform in 2012/13?

The last year has seen significant progress towards achieving this objective.

Against a target of 75% emergency adult admissions to be seen and assessed by a relevant consultant within 12 hours of the decision to admit or within 14 hours of the time of arrival at the hospital in medicine and general surgery, we achieved 80%.

As we met this target and are working towards 90% which will be monitored by the commissioners, our stakeholders have agreed that we should replace this with a new challenge and have selected end of life care (see page 37) but we will of course continue to ensure high performance on this crucial ambition.

But we have done more….
In addition to putting arrangements in place to ensure patients can be reviewed by a consultant within 12 hours of their admission, the Trust is making other innovations and investments to help deliver high quality emergency care, including:

- therapists (eg physiotherpaists, occupational health therapists) working extended days throughout the week and also at weekends to ensure they can review patients during the evenings

- at the Chelsea Children's Hospital, where consultants already provide a resident extended hours service, we are recruiting more consultant medical staff so that we can have provide this service 24 hours a day, seven days a week

- having additional consultant medical staff on our wards reviewing patients at weekends

All of these contribute to increased patient safety and clinical effectiveness, which are a core part of our hospital's services.

During autumn 2012 the Regional Health Authority reviewed adult emergency services at all London's hospitals against a set of service standards that had been developed for acute hospitals. Of the 56 separate standards that were assessed, Chelsea and Westminster Hospital met more than any other hospital in London. These standards

covered a range of aspects of care, from safety through to patient experience and communication, and their achievement bears testament to the commitment of our staff to work flexibly to deliver high-quality patient care.

Part 2

Our priorities for quality improvement 2013/14

Priority 1: Patient Safety

To have no hospital associated preventable VTE

Why is this important?

VTE is one of the most common preventable causes of hospital deaths and can be reduced by providing preventive treatment (see page 24 for more information).

We have kept this priority from last year because, although we have made good progress, we have not yet achieved our target.

What will we do in 2013/14?

- We will continue to complete VTE risk assessments for adult patients on admission to hospital and prescribe appropriate preventive treatment, where required, but with the aim of achieving a target of above 95% rather than 90%.

- We will continue to perform monthly audits on each adult ward to find out whether patients receive appropriate medicines and/or compression stockings to ward off blood clots. VTE link nurses will raise awareness of the issues with doctors and nurses on wards that don't perform as well as they should.

- We will continue to identify patients who developed a VTE during or within three months of admission, but who did not receive appropriate preventive treatment. In these cases, we will continue to perform in-depth root cause analysis to find out what happened so that we can prevent it happening again.

- We will focus on addressing the contributory factors we found in preventable cases of VTE in 2012/13. These included no or inaccurate VTE risk assessments, delayed prescribing of preventive treatment on admission and/or after a procedure and not giving patients preventive treatment when prescribed.

We will do this by:

- Continuing to provide monthly feedback on completed VTE risk assessments by ward and department and following up on the areas which do not meet the 95% target

- Setting up a multidisciplinary$_{G}$ group to look at why preventive treatment was delayed or omitted, and looking in particular at those drugs that help prevent VTE.

- Continuing to educate medical staff about the importance of prompt prescribing of preventive treatment.

We will continue to offer our VTE patient information leaflet *'Are you at risk of blood clots?'* to all patients admitted to hospital, all pregnant women and all patients requiring a lower limb plaster cast.

How will we track progress?

We will track progress by continuing to review weekly and monthly the number of adults who are assessed for their risk of VTE when they are admitted to hospital, those patients who acquire a VTE that could have been prevented (monthly), and check how many were given appropriate preventive treatment (monthly).

We will continue to monitor periodically whether patients receive the VTE information leaflet and will take action if the results show compliance of less than 75%.

We will monitor monthly uptake and completion of our online training module on VTE prevention and treatment for all doctors, with the aim of achieving 75% over 2 years.

We will continue to perform monthly VTE ward rounds in the Maternity Department to check pregnant women have been given appropriate VTE risk assessments and offered appropriate preventive treatment. We will roll out the VTE ward rounds to medicine and surgical wards quarterly and provide immediate feedback to ward staff.

How will progress be reported?

Progress will be reported at the Thrombosis and Thromboprophylaxis Committee$_{G}$, the Trust Executive Quality Committee$_{G}$ and the Assurance Committee$_{G}$—see Annex 6 for the Trust Committee structure.

Priority 2: Patient Experience

Continue to focus on communication, discharge and delivering safe and compassionate care to all our patients

Why is this important?

It is important that we continue to listen and respond to the feedback from patients and families we need to build on the work that we have taken forward over the past year. Our patients are telling us that there is room for improvement in how we communicate and in the discharge process. Our specific focus on the care of older people has been broadened this year to reflect the need to deliver compassionate care to all our patients. We will make these areas our priorities and part of our quality strategy.

Underpinning all of this work we will continue to integrate our Trust values so that every member of staff understands their responsibilities and has discussed their individual commitment in their appraisal and this is why we have maintained this as our third priority.

What will we do in 2013/14?

Communication
Last year we initiated a range of measures to improve communication as described on page 26 and we will continue to build on this work to ensure that our communication is kind and respectful.

We will develop a number of different ways to listen to the experience of patients, to learn from this and make changes. Through senior team visits, managers, non-executive directors and governors we will speak directly with patients and families to understand their experience of care and treatment. This will build on our existing feedback from concerns and complaints while continuing to use a range of patient surveys.

To communicate our learning about the patients experience and the related improvements that we make, wards will have a *'You said—We did'* noticeboard which will be updated each month.

We will improve the co-ordination, continuity and communication of care. To do this we will ensure that there is a clearly identifiable nurse in charge of each ward on every shift and develop specific expectations of this role. We will develop bedside plans of care within our wards to engage patients in their plan of care and enable continuity and communication between staff members. We will measure improvement through an evaluation of bedside care planning through audits and through specific questions in our periodic patient surveys.

We will deliver training to appropriate groups of staff to ensure they have the communication skills to support patients who are anxious or distressed. We will also provide customer care training for staff to ensure that they communicate with kindness and respect.

Discharge
We know that there is a continuing need to revise and improve the discharge process for patients to ensure that we focus on achieving safe, timely and effective discharge. In response to this, we have established a project team with representatives from hospital and community services who will continue to plan improvements in our discharge process.

We know that patients don't always know who to contact if they are worried following discharge. We will provide patients who are being discharged with a card and contact details so that they know who to get in touch with. We will monitor this through our periodic patient surveys.

Having piloted post discharge telephone follow up, we will identify ways to increase the number of patients that we contact in this way following their discharge and the patients that this is most useful for.

Delivering safe and compassionate care for all our patients
We will develop our environment and the support we provide for people with dementia and their carers. To do this, the refurbishment of Edgar Horne Ward will focus on ensuring it is more helpful for those with dementia. We will take forward further training for staff in meeting the needs of those with dementia and will develop access to information and support for informal carers of those with dementia

We will maintain the comfort rounds that were implemented last year and introduce these to our remaining ward areas. We will also evaluate the effectiveness of these with patients' families and staff.

We will establish a preventing harm group with representatives from relevant professions and community agencies, which will focus on two key areas of harm—building on last years' work in reducing the incidence of falls and on reducing the occurrence of pressure ulcers.

We will continue to ensure that we meet patient's nutrition and hydration needs through nutritional screening and protected mealtimes. We will work with our volunteer service to further develop our support to patients during mealtimes.

Focussing on compassionate end of life care will be an additional priority—see page 37.

How will we track progress?

We will track progress through our quarterly board reporting to include the main indicators of performance for both patient and staff experience.

Complaints will be monitored against these three themes: communication and discharge as measured last year and a new indicator, complaints relating to attitude and behaviour for 2013/14 which will be used to measure compassion. We will continue to measure safety through regular monitoring of falls (see page 42) and pressure ulcers (see page 46).

We will also have a structured programme of both postal and realtime survey results (undertaken while still in hospital) to track our progress.

How will progress be reported?

Progress will be reported through the Patient and Staff Experience Committee and the Assurance Committee—see Annex 6 for the Trust Committee structure.

'HOMEWARD BOUND'—further enhancing discharge planning for our patients
This is a new development that started over the last year and is developing in every ward area. A patient focussed meeting comprising of a daily short 'board round' to ensure timely communication and effective discharge planning takes place among the multi-disciplinary team (MDT). These meetings differ from ward to ward and involve the Nurse-in-Charge, FY1s/FY2s$_{G}$, Discharge Co-ordinator, physiotherapists and occupational therapists.

Planning a patient's discharge in advance of their planned discharge date is extremely important as effective planning ensures that tasks that need to be completed are done before the patient goes home. The role of the 'board round' is to make sure that the MDT is communicating this and is working together effectively towards a safe and timely discharge. The 'board round' is also designed to give teams a daily opportunity to update each other and to mutually agree on specific care goals, plans, dates and tasks to be completed.

The 'board round' has been seen to improve multi-disciplinary communication, teamwork and efficiency, as well as patient care and communication. Each ward is unique and has a particular way of working. Craig Edlin (Clinical Lead for Rehabilitation) and Caroline Fenwick (Stroke Co-ordinator) highlighted—"It can be quite difficult to get off the ground and needs a lot of pushing but once it's in place and you've found a way of embedding it in to the ward routine it's a really effective way of working."

The daily 'board rounds' are being rolled out ward by ward, so eventually every ward will have a daily 'board round' embedded into its routine.

Priority 3: Patient Experience

To be in the top 20% of acute Trusts nationally for staff engagement[G] and staff appraisals as measured by the NHS staff survey and to ensure our agreed Trust values inform everything that we do

Why is this important?

We want to ensure the highest quality care for patients being treated at Chelsea and Westminster and the highest quality environment for all staff working here. Research tells us that there is a positive relationship between staff motivation, wellbeing and patient experience. We understand the importance of all staff understanding the role they have in ensuring the highest quality of care for patients. To enable this we have focused on the four Trust values—safe, kind, excellent and respectful—and in 2012/13 we defined the behaviours that underpin everything we do. This will continue to be a priority in 2013/14.

What will we do in 2013/14?

We will build on our work relating to values to develop individual commitment in appraisals explaining how each individual will ensure they live the values of the Trust.

The feedback staff have given us through the annual staff survey has been used to develop a Trust-wide action plan, and local action plans, linked to the Trust values. These will be used as the main basis for taking action to improve our engagement with staff.

We will remain in the top 20% of Trusts for staff engagement as shown in our annual staff survey.

We will run four campaigns for staff throughout the year to focus on each value in turn: safe, kind, excellent and respectful. Each campaign will highlight aspects of patient experience related to the values.

We will build on our existing work to develop recruitment methods to assess values and behaviours so that we check whether staff are likely to meet our values when we recruit.

We will increase appraisal rates to at least 90% in order to be in the top 20% of Trusts.

Staff will use examples of feedback from patients and other sources within their appraisal.

We will include the Trust values and patient experience themes and stories into our training programmes.

We will improve on three key areas of patient experience that have been highlighted in our annual inpatients survey.

How will we track progress?

We will track progress through our quarterly reporting to the Board include the main indicators of performance for both patient and staff experience. This will include our annual staff survey and in-year staff pulse surveys[G] and our staff engagement measures. Appraisal rates will be tracked and reported monthly to divisions and the Trust Executive Team. The staff survey action plan will be reported through the executive meeting.

How will progress be reported?

Progress will be reported through the Patient and Staff Experience Committee and the Assurance Committee—see Annex 6 for the Trust Committee structure.

Priority 4: Clinical effectiveness

To improve choice and quality in End of Life care

End of life care is about the total care of a person who is seriously ill and who is not going to get better. This phase of a person's life may last for weeks, months or years although it is usually described as the last year or so of life before death.

End of life care extends to relatives too; they may also need information and support, both before and after their loved one dies.

Why is this important?

We only have one chance at looking after people well at the end of life. Bad experiences can blight what time patients have left and linger in the memories of those left behind.

If we know that someone might be in the last year or so of life, we can give them the information they are ready for and help them decide on a care plan that best suits their individual needs and preferences.

For example, some people may not want all the treatment on offer or may prefer to stay out of hospital. This means making sure that the right care is in place for them to be looked after at home. And it means making them as comfortable and free of pain as possible and giving them the emotional and practical support they need.

What will we do in 2013/14?

Our stakeholders said that we should be providing patients at the end of their lives with high quality care that focuses on dignity. They said we should direct our efforts to factors that improve the quality of life, rather than focusing solely on what can be measured. So we will:

- Draw on evidence from national audits, complaints and local information to look at the service we are currently providing and how it might be improved.

- Start a service for volunteers to spend time with dying patients who have no visitors

- Survey relatives of those at the end of their lives to obtain feedback about our services. This will be part of our 2014/15 plans

Our stakeholders said that we should communicate well with the person at the end of their life and their family and provide and document a care plan. They told us that the care we provide should take account of individual needs and preferences. So we will:

- Assess our end of life care service against national standards set out by NICEG: these include communication and information; individual assessment; care planning; and coordinated care.

- We will also look at guidance from the national End of Life Care Programme: The Route to Success in end of life care—achieving quality in acute hospitals 2010, and from that, and the assessment against NICE quality standards, agree a strategy for improving choice and quality in end of life care across the hospital.

- Ensure that patients choices around end of life care are recorded on the end of life care database so that we and our colleagues in community services know what people want at the end of life and can support those choices

Our stakeholders told us that we should train our staff in end of life care. So we will:

- Assess the need for hospital-wide training in end of life care and provide training where needed.

And they said that when patients are dying in hospital, we should explain the Liverpool Care Pathway so we will:

- Train staff in how to discuss the Liverpool Care Pathway with patients and their relatives

How will we track progress?

We will track progress every four months in line with the meetings of the End of Life Care Committee:

- We will develop an End of Life Care Strategy by the end of quarter 2 focusing on the elements that contribute to, and improve, quality of life. We will include complaints, and how we have responded to them

- We will review the report from the Co-ordinate My Care Team to check how many patients we are adding to this database and of those how many are offered conversations about future care

- We will produce a report on training needs in end of life care, including the Liverpool Care Pathway, by quarter 3 and we will use this to plan training for 2014/15

- We will review progress on the new volunteer service including uptake

How will progress be reported?

Progress will be reported at the End of Life Care Committee$_G$ and at the Trust Executive Quality Committee—see Annex 6 for the Trust Committee structure.

The Liverpool Care Pathway: Integrated care for the dying
In common with many hospitals, the Trust uses a document based on guidelines to help staff ensure that they give the best care to patients when they and their families agree that they are in the last hours or days of life.

The Liverpool Care Pathway, as it is called, helps staff to focus on what is really important, including pain relief, spiritual and emotional needs and practical support.

The pathway has attracted some unfavourable media coverage because it has not always been used as it should be and families have felt excluded from the decision-making process. As a result it is the subject of a national public consultation and we will be guided

by the recommendations arising out of that consultation when they are published. In the meantime we will do all we can to ensure that the voices of the dying and their relatives are heard and that we respect their wishes. We will also use our 'Medicine for Members'[G] public forum to talk about the Liverpool Care Pathway and address any misconceptions.

Our Palliative Care Service—a relative's story

From the moment we were linked in to the Palliative Care Team at Chelsea and Westminster Hospital, hope returned. For the first time since mum's diagnosis I felt I could breathe. We desperately needed a constant; someone we could trust. We found an entire team—a cross-disciplinary one at that—the medical and nursing team.

As a result, mum's life has been prolonged and on most days, Mum enjoys good symptom control. This has not come easy—it has taken absolute dedication, persistence and unwavering kindness from a first class team of medical professionals, 'our team'. It feels like a partnership, one which as mum's primary carer I have been welcomed and listened to and, most importantly, heard. There are no barriers, the team are always within reach and for that I am eternally grateful. I cannot stress enough how important that access and support has been for me. I would not have coped as well as I have without it. Mum would not be alive without it. This is a fact.

When we near mum's end of life, as a daughter, I must be certain that we did all that we could and then some, for mum. I will cherish and hold on to our team at Chelsea and Westminster Hospital—I know they care and are rooting for mum, for us.

Peace and dignity at the end of life: The Butterfly Room

The Butterfly Room on the newly renovated David Erskine Ward aims to provide a peaceful non-medical environment for patients in the last days and hours of their lives, where they can die in peace and with dignity.

The Butterfly Room's facilities include a sofa bed and a kitchenette so that relatives can stay over and spend valuable time with their loved one. "We wanted to create a home away from home environment, away from the hustle and bustle of the main ward," explains Ward Sister Lesley-Anne Marke who developed the idea for the room.

"Because our ward specialises in palliative care, looking after many older patients with serious respiratory and rheumatology conditions, it is inevitable that some of these patients will die here. The Butterfly Room means that family members can have some privacy during this difficult time," she adds.

The Butterfly Room was made possible by a donation from the Friends of Chelsea and Westminster Hospital.

Part 3

Review of quality performance

How the Trust identifies local improvement priorities

We are committed to understanding and responding to what our patients tell us about their experiences of care at the Trust and there are several ways in which we actively seek the views of our stakeholders to determine our priorities for quality improvement.

As a Foundation Trust, we have the benefit of a well-established and active Council of Governors. The Council represents the views of patients, public and staff to ensure that their views and experiences are heard. Governors hold frequent 'Meet a Governor' sessions for this very reason. And they regularly take part in senior nurse and midwife clinical rounds to find out for themselves how care is delivered to patients. When things are not right they make a note of them and check to see what progress has been made to rectify them at subsequent visits. In their role as a critical friend the governors are consulted on many aspects of the hospital's activities and may participate in the work of teams set up to carry forward particular projects. The perspective they bring is invaluable.

The Council of Governors Quality Sub-Committee is an important source of views and feedback and has a specific remit to help identify priorities for quality and advise on the content and focus of the Quality Report and plans for quality improvement. Members include patients, a representative from the Kensington & Chelsea Local Involvement Network (LINk), now replaced by Healthwatch Central West London and our commissioners (CWHH)$_{G}$. They not only feed back the experiences of those they represent but their own, where relevant.

This group has had a key role in agreeing the Trust's Patient Experience Strategy, in particular the focus on discharge planning. They have also agreed the 2012/13 priorities and what local performance indicators we will measure, and the relevant content for the Quality Report.

We seek clinicians' views via the Trust Executive Quality Committee. And we take an inclusive approach to business planning, ensuring that all staff have the opportunity to be involved in the process. The feedback from open meetings with staff and governors during business planning has informed the content of the Quality Report. New this year the Patient and Staff Experience Committee has provided a focus for quality monitoring with the input from users of the Trust services in collaboration with Trust staff. As required during the year there are also mechanisms for more focused discussions on specific areas.

We actively look at complaints, incidents and feedback from service users to identify trends and areas where we can improve our services.

The various patient forums in the Trust influence how we design and deliver our services with an emphasis on quality. They represent specific areas and include the Patient Environment Action Team$_{G}$ now renamed nationally as the Patient Led Assessment of the Care Environment (PLACE)$_{G}$, Maternity Services Liaison Committee, HIV Patient Forum, Paediatric Forum the Carers Network, the Joint Research Committees, Bariatric Patient Support, the Stroke Forum, the Ex-Intensive Care Unit Patents Forum and the Learning Disabilities Steering Group.

Your role

We welcome your views on quality priorities. The Trust's website has a dedicated section on quality and safety at www.chelwest.nhs.uk/transparency/quality-safety. You can also give your feedback in this section.

Feedback about our Quality Report/Account will be welcomed through our dedicated email quality@chelwest.nhs.uk or by contacting the Director of Nursing and Quality on 020 3315 6599.

Our Quality Campaign for patients and staff

This campaign, which is all about delivering excellent and safe services with kindness and respect, was launched in October 2012 to co-ordinate different aspects of quality linked to the Trust's values and is another approach to make quality real at the front line.

The Quality Campaign focuses on a different theme every fortnight. This is featured in the Trust's magazine *Trust News* and the *Daily Noticeboard* email bulletin which is circulated to all staff. The campaign provides a clear and simple overview on how staff can contribute to high quality and safe care in relation to national standards.

Complying with the National Health Service Litigation Authority (NHSLA) and the CQC essential standards of quality and safety are among the ways that the Trust can measure and monitor its performance to improve services for patients.

Several areas have been highlighted to staff since October 2012. These include:

- patient information and consent
- reporting and learning from incidents
- assessing, monitoring, and improving the quality of service provision
- complaints handling
- values and behaviours

The campaign is an indication of just how much quality matters to us, and the Trust's commitment to responding to what patients tell us about their experiences of the care they receive at the hospital.

Linked to our campaign and a key part of our quality work are the Trust's Quality Awards, which are open to all staff in the Trust. There is further information on page 67.

Measuring what matters: local quality indicators

Safety

When we discussed monitoring performance indicators with our external stakeholders they asked us to explain why we measure what we do. So we have grouped the indicators into themes and described how they contribute to quality. The full range of quality indicators is on page 73.

Infection control

Patients are more vulnerable to infection when they are in hospital and reducing the risk of this is a top priority for us. There are some healthcare associated infections that we have a statutory responsibility to report on. These include Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia and *Clostridium difficile* (*C.difficile)*.

The Department of Health sets targets to reduce the number of new cases of these infections each year. Whenever a patient becomes infected, we complete a detailed review to find out how it happened and see what changes to our practice we may need to make.

Last year the Department of Health MRSA target was for a maximum of 2 hospital cases. We had 1 case and next year we aim to have none. The equivalent target for C.*difficile* was for a maximum of 31 hospital cases. We had 15 and again aim to cut that number next year. We have shown that we can reduce the incidence of these infections by good infection prevention and control, making sure that everyone is involved in this.

Thorough hand washing and good practice around the use of intravenous lines can help reduce the risk of infection. We train all our staff on hand hygiene and monitor compliance with this every month. Results are recorded in our online data management system, and all the information passed on to the Infection Prevention and Control Committee**s**.

The completion rate for the monthly audit in 2012/13 was 96%; we want to achieve 100%. We aim for 95% compliance with standards across all clinical areas. Our compliance rate for 2012/13 was 95%.

Another initiative which has had an impact on improving practice is the Saving Lives Care Bundles which were designed by the Department of Health (DH) in 2007. These are audit tools that are used to monitor the effective management of intravenous lines and urinary catheters. The use of each care bundle is checked regularly and the results are reported to the Infection Prevention and Control Committee and clinical divisions.

Our target for compliance with standards around the use of central lines—small tubes or catheters placed in large veins in the neck, chest, or groin— is 90%: we achieved 94%.

Similarly, we aim for 90% compliance with standards around the use of peripheral lines—tubes placed in smaller veins, and often referred to as a drip. Our compliance was 80% in 2012/13; to help us raise our percentage a new labelling process has been introduced. We exceeded our compliance target of 90% around the use of urinary catheters by 2%.

Trips, slips and falls

Trips, slips and falls often have significant consequences for patients, particularly older patients. A fall is the main cause of death from injury among the over-75s in the UK and can lead to loss of confidence and social isolation. Falls cost the NHS £2.3 billion a year. Yet falls prevention often gets overlooked.

Some of the risk factors for falls can be modified, and all patients who have had a fall are assessed for their risk of a subsequent fall and a care plan put in place. Both of these documents are electronic and readily available to patients, their carers and all staff caring for the patient at the bedside.

Successful projects over the past 18 months have included:

- the purchase of fall alarms, which are especially useful for people with cognitive problems as this increases the risk of a fall
- fall prevention care plans
- design and distribution of patient/ carer information about falls prevention
- patient wrist bands which vulnerable patients wear that alert staff to the fact that they may be at particular risk of fall

Three key measures of effectiveness are used by ward and falls prevention teams:

- Monthly data on slips, trips and falls by ward and severity of harm (from none to death)
- Fall rate (falls per 1000 bed days$_{G}$): the national average is set at 5.6/1000 and our threshold is 3/1000; in 2012/13 the threshold wasn't breached in 10 months of the year
- A risk assessment and care plan developed within 12 hours of admission

Learning from mistakes to improve safety

When things go wrong, or incidents are narrowly avoided, we need to find out why it happened so that we can take steps to avoid a recurrence and make Chelsea and Westminster an even safer environment for patients and staff.

But we can only do that if we know about the things that might cause problems. That's why staff are constantly encouraged to report all mistakes (incidents) promptly, however trivial they may seem. It's just as important to know about the things that nearly happened as about those that did, therefore we encourage the reporting of 'near misses' as well as 'actual' incidents.

The evidence shows that teams, departments, and organisations that report more safety incidents are more willing to learn from their mistakes and to promote a culture where patient and staff safety is a high priority. A reporting culture indicates an open and healthy organisation.

The number of patients treated at the hospital varies from day to day so rather than simply measuring the number of incidents reported we compare this figure with the proportion of patients treated to arrive at the incident reporting rate. This is a measure of the rates of patient safety incidents per 100 admissions$_{G}$ at the hospital.

Experience in other industries shows that as an organisation's reporting culture becomes established, staff become more likely to report incidents. But we know that not all incidents are reported, particularly those regarded as trivial. So we constantly remind staff about the importance of flagging up anything that could or did go wrong and encourage them to tell us about it. It should be second nature for staff to report incidents (including those that led to no harm or were prevented, the near misses) as they have confidence in the investigation process and understand the value of reporting and learning from incidents.

We look at trends in all incidents but investigate the more serious ones (or those that could have been serious, the near misses) in more detail using root cause analysis, a way of understanding what went wrong. One of our objectives this year is to improve the speed at which we complete these investigations and we will seek further improvement in 2013/14.

We make an effort to ensure that information relating to incidents reported is accessible, making sure that staff see how their incident reports are being used to improve patient safety and that patients and staff involved in incidents are treated fairly.

Reporting incidents is essential but even more important is how we respond to and learn from them and that includes ensuring that changes happen to improve services for patients.

Never events

Never events are rare but are serious patient safety incidents that, by definition, should never happen.

The list, published by the DH, consists of 25 types of events or categories and includes incidents such as surgery on the wrong part of the body or surgical instruments or swabs being left in the body after a procedure.

At Chelsea and Westminster we had three never events in 2012/13. A mole was removed from a patient's back, which was not the mole intended to be removed; the wrong side of an ankle was operated on in error; and a swab was not removed from a patient after treatment for blood loss after the birth of her baby.

Like other serious incidents, these incidents are always explained to patients, a full apology is given and the incident is thoroughly investigated with a report back to the patient. We have been working hard looking at how things work and how we can be confident that they do, in order to ensure that never events cannot happen. Some of the changes we have introduced as a result of learning from these incidents include standardising the size of medical swabs in order to simplify counting in and counting out at the end of a procedure, updated documentation to ensure that adequate additional checks are undertaken, revised the process and practices for marking fingers and toes to ensure consistency amongst all staff and introduced a standard to ensure that marking on the patient's body indicating where surgery should take place remains visible throughout the surgical procedure.

Patients whose condition is worsening

Patients admitted to the hospital expect prompt treatment should their condition worsen. We have therefore set up two quality indicators to monitor how well the Trust identifies these patients:

- The percentage of adult inpatient observation charts accurately scored

- The number of cardiac arrest calls in patients where no prior action was taken to stop their condition worsening

Chelsea and Westminster introduced a track and trigger system known as the Chelsea Early Warning Score (CEWS) in 2006 to prompt a rapid response in patients whose condition is worsening. CEWS tracks and scores a patient's vital signs (heart rate,

breathing rate, temperature and blood pressure) on a colour coded observation chart, flagging up any danger signs, and triggering a review of care.

The accuracy of the CEWS scoring on observation charts is a good indicator of whether deteriorating patients are being correctly identified. The target for this indicator is 85%; the Trust achieved 89% in 2011/12. The CEWS score is being replaced by a national scoring system—see notes on page 77 for further information.

There are two main categories of cardiac arrests: unpredictable and predictable. Predictable cardiac arrests are divided into three further categories, including failure to recognise deterioration. In 2011/12 there were 7 incidences of cardiac arrests due to failure to refer, which prompted in-depth analysis to look at the contributory factors and prevent it happening again. In 2012/13 the number of cases fell to 2.

Venous Thromboembolism (VTE)

Preventing VTE is one of our priorities for 2013/14—please see page 24 for further information.

Clinical effectiveness

Mortality

The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect.

The HSMR compares the expected rate of death in a hospital with the actual rate of death. It looks at those patients with diagnoses that most commonly result in death- for example, heart attacks, strokes or broken hips. For each group of patients it can be worked out how often, on average across the whole country, they survive their stay in hospital, and how often they die. This takes into account their age, the severity of their illness and other factors, such as whether they live in a more or less deprived area. The number of patients expected to die at each hospital is then compared with the number of patients that actually die. If the two numbers are the same, the hospital gets a score of 100. If the number of deaths is 10% less than expected they get a score of 90. If it is 10% higher than expected they score 110.

The Summary Hospital-level Mortality Indicator (SHMI) is a similar indicator but with some differences. HSMRs reflect only deaths in hospital care where as SHMI also includes deaths that happen outside of hospital care within 30 days of discharge. The HSMR focuses on 56 diagnosis groups (about 80% of in-hospital deaths) whereas SHMI includes all diagnosis groups (100% of deaths). The HSMR makes allowances for palliative care whereas the SHMI does not take palliative care into account.

The Trust scores for HSMR and SHMI are both low (see pages 71 and 73) and for SHMI we are the 5th lowest in the country.

Emergency surgery

Patients waiting for emergency surgery need to get to theatre as soon as possible, and are prioritised by a senior doctor according to level of urgency. We track how long each patient has waited against the category to which they have been assigned to make sure we are getting this right.

There are three main categories:

- **Immediate:** cases that need to go to theatre within 60 minutes (eg life-threatening bleeding or airway blockage).

- **Urgent:** within 24 hours (eg stable uncomplicated appendicitis), which make up most emergency cases.

- **Expedited:** within 4 working days (eg small wounds, fractures with swelling). In some cases, patients can be discharged and return on the day of surgery.

By carrying out surgery at the weekend the proportions of patients operated on within the timeframes required for cases categorised as urgent rose from 95% in 2011/12 to 98% in 2012/13 and from 98% in 2011/2012 to 100% in 2012/13 for expedited cases.

Our target is 100% and we will look at what else we can do to achieve this in all categories.

Pressure ulcers

Pressure ulcers, often known as bedsores, are graded by severity. We changed the way we categorise this so that we can compare our performance with other London hospital trusts. The new system was only introduced three months ago and therefore we are not yet in a position to make this comparison.

The number of new cases seems to have risen, but there has also been an increase in the number of patients who have ulcers present on admission to hospital (community acquired) over the past year, which suggests that it's the reporting of cases that has improved rather than a genuine rise in new cases.

Grade of severity	Target for 2012/13	Actual
Grade 2	50	70
Grades 3 and 4	31	38

In a bid to reduce the numbers of new cases, we have introduced a care bundle[G] of documentation, which will be rolled out across medicine and surgery. We are also setting up a Pressure Ulcer Committee, which will have representation from community services, to help us improve our performance, track progress and ensure care stretches across the hospital and community.

Good nutrition

The average estimated prevalence of malnutrition among patients admitted to hospital is 28%. Good nutrition is therefore important for patient safety, clinical effectiveness, and the patient experience.

To make sure that patients are eating properly, we screen them for malnutrition within 24 hours of admission, and weekly thereafter, and then put in place nutritional care for any who are already malnourished or at risk of being so.

The nutritional care we provide is fully integrated, involving dieticians and catering staff, and extends right through to discharge. Various types of support are provided, including

additional prescribed snacks, protected mealtimes, dining companions/feeding assistance, referral to dieticians for extra help, and nutritional supplements.

Daily reports on the results of nutritional screening has raised the profile of nutritional care across all disciplines and has increased the number of patients who are screened within 24 hours of admission from 40% to 85% (our target is 90%), and those who are rescreened within a week from 0 to 71% (our target is 90%).

The daily screening reports are used to audit current practice and highlight any areas requiring improvement, while the Trust reports monthly on the percentage of patients given a first and second screen.

We are always looking to see how we can improve our nutritional care. In March 2013 we started screening children admitted to the hospital, and we are currently working on:

- providing electronic boards for ward kitchens to display up to the minute accurate nutritional score, status and nutritional requirements for each patient; these will update every 3 minutes.
- improving the high protein and high energy menu choices we offer
- comparing admission and discharge weights as a measure of effectiveness
- making sure that 90% patients who are prescribed snacks and supplements actually consume them

Patient Experience

Complaints

No matter what information we derive from surveys, a written complaint indicates that for some patients they have not received the high-quality care we aim for. Formal complaints provide an important mechanism by which the Trust can assess the quality of services provided. The Trust strive to follow best practice for public bodies, recommended by the Parliamentary and Health Service Ombudsman (PHSO), in responding to complaints.

Complaints responded to within target time (formal complaints responded to within 25 working days)

It is essential that issues raised from complaints are dealt with in a sensitive and timely manner so as to prevent re-occurrence or escalation of incidents. We aim to respond to complaints within 25 working days from receiving the request. This year 81% of complaints received were responded to in 25 working days. This is against the Trust target of 90%. As a result we have now initiated weekly reviews of all complaints that are due for response in order speed up responses.

During the past year considerable effort was made to improve how we manage complaints by responding to complainants on a more personal level and by improving the quality of responses.

Complainants are now contacted by telephone to see how they would like their complaint to be investigated and to agree a timescale for resolution. Historically a complainant would simply have been sent an acknowledgement letter outlining the issue to be investigated.

The Trust has determined that the initial contact and completion of action plans will be reported to the Trust Board and has determined a performance target of 90%.

Complaints re-opened: reported one month behind

If a complaint is properly investigated and the complainant is kept informed about the type of investigation and feedback they receive it is more likely that a successful local resolution is achieved for the complainant. The goal of the Ombudsman is to see an NHS that is much better at listening to patients and their families and responding to their concerns. Local and early resolution of complaints for individuals is important.

During the year 2010-2011 10% of the complaints received were reopened. During 2011-2012, 6% of the complaints received were reopened. This year 23 complaints (6%) were reopened; of those 18 have now been resolved through further local resolution either by writing again to the complainants or by meeting with them.

Complaints upheld by the Ombudsman

All complainants whose complaint relates to NHS funded care have the right to have their complaint reviewed by the Ombudsman. The Ombudsman will carefully consider the issues that each complaint raises, examine how the NHS Trust responded, take clinical advice if needed and then reach a decision. The initial decision is whether or not the PHSO will investigate the complaint. If they decide to investigate they write to the Trust with their findings and any recommendations. Last year 12 of our complainants (3%) were not happy with our local responses and referred their complaint to the Parliamentary and Health Service Ombudsman for an independent review.

This year a total of nine complaints to date have been referred to the Ombudsman. In eight cases, the PHSO decided they would not accept the complaint for investigation and would take no further action. In one case the patient was referred back to the Trust for further local resolution and following further work to resolve the issues the Ombudsman advised they would take no further action. The views of the Ombudsman in almost all these situations indicate that the Trust's actions were appropriate.

From April 2013, the Ombudsman's office has advised that they will begin investigating and sharing reports on more of the complaints. This is part of their new strategy 'More Impact for More People'. They will be investigating thousands rather than hundreds of complaints each year. The Ombudsman will continue to publish figures for the number of complaints they investigate about each organisation.

Complaints (type 1 and type 2)—communication, discharge and older people

The Patient Experience Strategy has been developed to improve the experience patients receive. The Trust identified three themes which were included in the Trust's Strategy and Quality Report for 2011/2012. The three themes were communication, discharge and care of the older person. During 2012/2013 complaints relating to attitude of staff have also been reported to the Patient and Staff Experience Committee and the Quality Committee. In response to the issues identified each division has developed action plans to improve the patient experience relating to the themes. These are reviewed and updated on a 3 monthly basis; the key achievements are reported to the Patient and Staff Experience Committee and the Quality Committee. A range of improvements and initiatives have been taken forward over the past year.

Once a formal complaint has been made, it is important that the process and outcomes are monitored so that lessons can be learned; changes to practice can be made and shared, with staff appropriately supported. Action monitoring forms are sent to divisions for completion and reported to the Risk Management Committee. All recommendations made at each stage of the complaints process are recorded on the risk management database by the patient advisers. A report is sent to the General Manager each quarter for progress to be updated.

Using complaints to drive improvements

A complaint can be defined by more than one category. The three main types of complaints (where the category listed is the primary cause of the complaint) in 2012/13 concerned:

- Aspects of clinical care or treatment (45%)
- Attitude or behaviour of staff (20%)
- Communication (11%)

We take patient complaints very seriously and have responded to them in various ways to improve the quality of care we provide, as the following examples show.

Support for new mothers—voluntary Maternity Breastfeeding Peer Supporters

The Maternity Department has had a Breastfeeding Peer Support Volunteer programme in place for the past two years. This continues to be successful in supporting women's needs for additional breastfeeding support on the postnatal ward.

There are currently 15 Breastfeeding Peer Support Volunteers, with 6 more recruited in the last quarter.

The project has been well received by midwives. The Trust's maternity service has now received Stage 3 Accreditation of the Baby Friendly Initiative**G**.

What you told us

"I must thank the fantastic team you have on your postnatal ward. As a first time mum, I was very nervous and really struggled with breastfeeding. Thanks for the superb support I received throughout my 3 days."

—Mother, Postnatal Ward

Doulas**G** now work on the wards and birthing unit to help women during the early stages of labour as part of a new initiative called NEST (Nurturing Essential Support for Transition to motherhood). And visiting hours for partners have been extended on the postnatal ward to encourage family bonding during the first few days of the birth.

Attentive nursing

An initiative originally developed on the David Erskine Ward last year has now been rolled out across the Trust. The comfort round emphasises the importance of regular checks on patients every couple of hours to find out if they are comfortable, free of pain and have any other needs.

Communication

Communication emerged as a key theme in the 2011/12 Annual Complaints Report and in national patient surveys. In 2012/13 it remains a core strand of the strategy to improve the patient experience at the hospital and is reflected in two of our priorities (priority 2 and 3)

Prompted by patient feedback it is now compulsory for all staff to wear large print badges, clearly showing their name and position, so that patients can easily identify who they are. And all key clinical areas will have *'You said—We did'* notice boards, summarising concerns raised by patients and what has been done to address them.

Measuring what matters—measuring at the front line

An important part of understanding how we provide care to patients and what needs to be improved is seeing what actually happens on the wards and in departments and so we have a number of ways of doing this:

Senior clinical rounds

We have translated the CQC$_{G}$ essential standards for quality and safety$_{G}$ into a series of prompts so that we can assess standards of care and treatment in each of our wards and clinical departments such as outpatients.

Clinical rounds are conducted twice a month by senior nurses and midwives and we encourage other staff, governors, and patient representatives to join us. On each round we look at one or two of the essential standards. This involves discussion with patients, families and staff and a look at the clinical environment and records. Afterwards we all meet to discuss our findings and agree an action plan to tackle any common themes to emerge. For example one round identified that improvements were needed to ensuring that all equipment was routinely and regularly reviewed as the stickers on equipment showed that maintenance was out of date. As a result there was a review of all equipment and the maintenance process was put back on track.

Board to Ward approach

We introduced these in March 2013. These involve senior nurses and midwives along with a member of the Trust Senior Management Team—including non-executive directors and governors—visiting clinical areas to which they have been assigned. The idea is to create a Board to Ward approach with senior clinical staff and members of the Trust Executive Team meeting patients and their families and making sure that senior staff are seen on the shop floor. Our other stakeholders including commissioners have been invited to attend and participate.

These visits focus on our priorities around safety, effectiveness, and patient experience. They also emphasise the Trust values of safe, kind, excellent and respectful. Anything arising from these visits is taken to the Senior Nursing and Midwifery Committee$_{G}$, the Patient and Staff Experience Committee$_{G}$ and are reported back to the Quality Committee and Assurance Committee plus relevant divisional meetings.

'Delivering excellence' reviews

'Delivering excellence' reviews were established in July 2012. Nurse leaders from each ward and department meet every three months with the Chief Nurse to review key clinical

indicators for their clinical area. A framework for these reviews has been developed which include aspects such as numbers of falls and pressure ulcers, infection control measures, patient experience and staffing.

This framework of periodic review aims to bring these various strands together while supporting the pivotal leadership role of the Ward Sister / Charge Nurse and Matron in leading their teams to deliver excellence through continual improvement in the quality and safety of the service.

These regular reviews also offer the opportunity for clinical leaders to meet collectively, to discuss successes and challenges and to identify any common themes emerging from their areas.

Delivering Care	Measuring Impact	Patient experience	Staffing	Staff experience
• Medication errors • Pressure ulcer incidence • Nutritional screening • MRSA, MSSA and *C.difficile* incidence • Falls	• Hand hygiene monitoring • Saving lives audits • CQC essential standards • VTE Assessment	• Formal complaints and informal concerns • Hospedia survey results • Single sex accommodation	• Vacancies • Appraisals • Sickness/absence • Mandatory training • Budget position	• Staff survey action plan

Care Quality Commission visit and alert

The health and social care regulator carried out an unannounced inspection of the Trust on 26 Jul 2012. The visit aimed to find out whether Chelsea and Westminster was meeting its essential standards of quality and safety. Inspections of this kind are normal procedure for all NHS Trusts.

The inspection was part of their themed inspection programme to assess whether older people in hospitals are treated with dignity and respect, and whether they are getting enough to eat.

The CQC inspectors visited three wards and departments in the hospital and spoke to staff, visitors and patients about care provision. Patients told the inspectors that they felt well looked after and that staff were attentive and caring. Feedback about the hospital, the ward environment, choice of menu, facilities and surroundings was generally positive.

The CQC found that the Trust met all the essential standards and their report is available at www.chelwest.nhs.uk/cqc-report.

A few comments from patients given to the CQC inspectors on the day include:

- “This hospital saved my life.”
- “I cannot tell you how much I respect [the staff] for what they have done for me.”
- “I love this hospital and this hospital loves me.”

The Trust received an alert during March 2013 from the CQC because some data sources suggested the Trust was an outlier for puerperal sepsis$_{G}$ and other puerperal infections within 42 days of delivery. The Trust worked with the CQC to provide a variety of information to clarify the situation. After extensive examination of information it is thought that this was a result of information coding where amendment was required.

Friends and Family test

The DH-led Friends and Family Test was implemented at Chelsea and Westminster Hospital in November 2012 prior to becoming mandatory for all Trusts in England from April 2013. The purpose of the test is to provide a simple measure of patient experience through a single question, the results of which are definable by individual clinical area and comparable between organisations.

The test is currently for adult inpatients and for those adults being discharged home from the A&E department. A response rate of 15% has been established as an initial expectation for both inpatients and A&E attenders. The test is conducted through the use of a post card and the Picker Institute manages the collation of results and the reporting of these to the Trust. Results are published on the Trust web site on a monthly basis.

The March results show that 94% of patients are either 'extremely likely' or 'likely' to recommend their care at Chelsea and Westminster. This is based on a 30% response rate and equates to a net score$_{G}$ of 20. The Net Score has risen from 12 to 20 since implementation of the test in November. However we need to increase the response rate so that the results are fully representative of patient experience.

What else have we done—examples of quality improvement

Our staff have been working hard to drive up the quality of services they deliver for patients over the past year focusing on patient safety, the patient experience, and clinical effectiveness. The following examples show how those themes make a difference in practice.

Safety

Cleaning endoscopes and preventing infection

A Quality Award was presented to the Decontamination Team during the year who greatly contributed to patient safety. The team established a new service to clean and decontaminate endoscopes used during patient procedures by combining the cleaning of endoscopes into one new and purpose built area.

Before this time there were five areas where endoscopes were cleaned. These areas did not comply with required standards to promote patient safety. Older machines that washed and disinfected the endoscopes often failed and this did not help to support good infection control procedures. Nursing staff also managed the cleaning of the endoscopes and patient care duties simultaneously which was challenging on their time to treat patients. There had been reported incidents due to poorly functioning washer disinfector machines and sometimes patient procedures had to be postponed.

When the new purpose built area opened in 2009 it offered updated specialist equipment and improved infection control procedures. The service permitted an expansion of Endoscopy Unit to ensure more patients could be treated quickly. Specialist decontamination staff were also trained and available to undertake the specific duties. This left nursing staff free to care for their patients. With the new working arrangements, European standards relevant to decontaminating this type of equipment were met for the

first time. This brought increased patient safety and positive patient experience due to procedures being completed in a timely manner.

What did the users of the new service say?

- Operating theatre staff: “Great service; very efficient.”
- Nursing staff: “This has made a real difference to our patients.”
- Kobler Day Care: “Excellent communication and service, very helpful staff.”
- Burns Unit: “A very good service, thank you.”
- Sister, Endoscopy Decontamination Unit (EDU): “I am very much impressed and more than happy and satisfied with the EDU$_G$ service. It has helped us a lot in improving and efficiently running our services.”

‘My medication passport’

The NIHR CLAHRC for North West London launched the ‘my medication passport’. The passport was designed and tested by patients and is a tool to help them manage their health by keeping track of their medications and key medical information.

The passport is available as a pocket booklet and downloadable smart phone application for both Android and iPhones from the CLAHRC website www.clahrc-northwestlondon.nihr.ac.uk.

The passport allows patients and carers to keep an up-to-date list of their medications by recording medicine name, dose, and timings for all their regular and as-needed medicines. It also allows changes in treatment to be recorded and will facilitate the communication of medical information between patients and healthcare professionals. Both booklet and electronic versions of my medication passport are flexible enough to enable patients to add details pertinent to their health and/or specific medication condition such as allergies and sensitivities, dates of vaccinations and screenings, home treatments and medication aids as well as hospital information if warranted.

Of use at any point in the patient’s care, in the community or hospital, ‘my medication passport’ provides the user with easy to retrieve key information to communicate to healthcare professionals, thus saving time for both and ensuring accurate information transfer.

Effectiveness

Improving efficiency on the Acute Assessment Unit (AAU)—therapies

In September 2011 new commissioning standards for adult emergency services were published. One of these stipulates that all patients must be comprehensively assessed within 12 hours of admission to the AAU and a plan for their care put in place within 24 hours.

To meet this standard the team now work two different shift patterns, and this change means that the Therapies Team, which has a key role in the comprehensive assessment of patients newly admitted to the unit, can see more patients out of hours. This in turn opens up the possibility of earlier discharge and fewer days spent in hospital and the impact of the extended service on these factors is now being evaluated.

Procedures for patient care from start to finish were reviewed and this highlighted several areas that needed to be improved including handover practice between different therapy teams, multiple assessments of the same patient by different teams, and allocation of patients to particular therapy teams based on written criteria rather than patient need.

As a result a combined initial assessment system was introduced, which means that teams now work together to allocate the patient to the team most suited to dealing with that individual's needs.

And to make it easier for other therapists and ward staff to know who everyone is, and what they do, contact lists of all staff in each team were drawn up, and each practitioner now wears a badge denoting the particular team to which they belong. These changes should reduce the time it takes for a patient to be initially assessed, improve handovers, and reduce the number of times patients are transferred between different therapy teams.

Patient Experience

Maternity Services: delivering excellence

In 2012/13, Chelsea and Westminster Maternity Services were honoured with several external awards in recognition of the high standards of care and professionalism for which we strive.

The Service won 'Best Obstetrics Venous Thromboembolism Prevention Programme' in recognition of its exemplary leadership on driving down the risk of potentially fatal blood clots (thromboembolism) in pregnant women.

Elsewhere, the All-Party Parliamentary Group on Maternity (APPGM) commended us for setting up the West London African Women's Service, which aims to meet the complex needs of women who have been subjected to female genital mutilation.

Supervision in midwifery aims to promote excellence and protect the public, and the supervisors team was awarded Local Supervisory Authority Supervisory Team of the Year 2012 for their work on producing an annual report. But our goal is to achieve world-class supervision of midwives, and we have set out a strategy containing 4 core themes as a priority over the next few years. These are:

- a reduction in patient safety incidents and the promotion of safe practice, ensuring that supervision of midwives performs strongly against recognised quality standards
- excellence in statutory supervision
- a focus on woman centred care
- leadership development and collaborative working

The supervisors have organised and run quarterly pregnancy and natural birth open days, and they offer off-site home birth workshops, in a bid to help women make a genuinely informed choice about how and where they want to give birth.

Speeding up access to medicines for 'Chelsea Pensioners'

At the annual Founder's day parade at the Royal Hospital Chelsea, one of the Trust's pharmacists got talking to the resident GP, and it became clear that there were areas of medicines management that could be improved, particularly for those who come to the Trust for outpatient appointments.

The STOPIT project at the Trust, which aims to cut down on inappropriate medicines prescribing, prompted the Pharmacy Department at Chelsea and Westminster to change the way it supplies medicines to Chelsea Pensioners.

Instead of the need to hand in a prescription at pharmacy outpatients, and waiting for it to be completed before being driven back via hospital transport, a 'no wait' process has been set up, whereby neither the driver nor Pensioner need to wait in pharmacy.

All prescriptions for Chelsea Pensioners are marked as such, and the driver who has brought the Pensioner to outpatients takes them back home as soon as the appointment is finished and they have dropped the prescription to Pharmacy. Once the medicines are ready, Pharmacy arranges for the driver to come back and pick them up at a mutually convenient time.

Prescription delivery was suggested as an area to be considered for 'vulnerable' patients by the former patient and public representative group, the Kensington and Chelsea Local Involvement Network, in the 2011/2012 Quality Report.

Other developments are planned:

- When Chelsea Pensioners come for their outpatient appointments, they will bring with them a printed list of all medicines they are currently taking. They will automatically qualify for the 'STOPIT review' if they are on six or more medicines.

- The outpatient letter to the resident GP will include not only details of what new medicines may have been started (as is the case at present), but also what medicines have been stopped and why (using STOPIT criteria). Alternatively, it may suggest that the GP stops certain medicines at a future review.

- Some red list drugs—which can only be prescribed by a consultant and need particularly careful monitoring because of potential or unknown side effects—will be put on a regular repeat and delivery system, to ensure that Pensioners don't run out of supplies before their next hospital appointment.

Making things better for patients: Community Musculoskeletal Service

In 2012/13 the Trust broke new ground by working with an independent organisation to run a new community musculoskeletal service for patients in Kensington & Chelsea. The team includes physiotherapists, osteopaths, psychologists, and consultants in orthopaedics, sports medicine, and pain medicine.

Patient choice is a key aspect of the service, which offers six locations for appointments, and a choice of physiotherapy or osteopathy, depending on patient preference. Patients can choose between three local diagnostic centres if they require any tests and any hospital if they require onward referral for surgery.

Every patient is assessed and managed in the community where possible, which cuts down on unnecessary waits for hospital appointments. Some patients have even been referred directly to surgery without the need to be seen as an outpatient first.

Innovative aspects of the service include electronic triage[G] of referrals; telephone consultations; a full pain management service in the community; and an efficient off-site

referral management centre, which means that patients can get an appointment at the service within a few days of seeing their GP.

All care records are fully electronic and available to all the relevant clinicians, so there is no need to repeatedly request the same information from patients.

The service started in September 2012 and consistently deals with 180 patients every week, 90% of whom are managed without the need for a hospital appointment or wait.

Inclusive services: holistic sexual health and wellbeing at CliniQ

CliniQ is a new holistic sexual health and wellbeing service for all transgender people, their partners and friends. It opened in February 2012 at 56 Dean Street in Soho, following feedback from the trans$_{G}$ community about the need for such a service.

The clinic is open every Wednesday evening and offers both walk-in and booked appointments for trans people who may not feel comfortable accessing mainstream health services. CliniQ offers sexual health screening, testing for HIV and hepatitis B, hepatitis B vaccination, liver function tests, cervical smears, contraceptive services, counselling, and advice and support.

The clinic is run by staff from a range of community organisations and includes 'welcomers', nurses, a counsellor, and peer support. It has received extremely positive feedback from service users.

The intention is to forge further links with other healthcare professionals. Through being kind and respecting the needs of trans people, in a safe and appropriate environment, CliniQ fulfils all the Trust values.

Volunteers at Chelsea and Westminster—(The Friends Patient Support Project, funded by The Friends of Chelsea and Westminster Hospital)

Volunteer mealtime coordinators continue to provide assistance on every ward, making sure that patients are able to eat their meals. Other volunteer projects include 'request a volunteer' for patients who would like some companionship, and 'by your side,' when a volunteer accompanies a patient during hospital appointments. Requests for these services have increased, and more volunteers are being recruited. 'Here to help' volunteers will be given training on customer care.

Digitising patient records

Patient and other data are held in digital and paper records. Many of the electronic resources are linked to some extent, but the sheer variety and quantity of paper records has made bringing them together a daunting task.

But the ambition is to transfer all these paper records to a comprehensive, real-time electronic system that is secure, reliable, easy to use and available to all those who need to access it within the Trust. In due course, the aim would be to enable commissioners, our primary and community care partners, and patients themselves to access selected data.

The framework for achieving this ambition took shape in 2012/13 after a competitive tendering exercise. Every part of the hospital took part in the consultation and development work, providing an analysis of their requirements and how best those might

be met. A phased roll-out of the new system (Evolve by Kainos Ltd) starting in two outpatient areas, will begin in May 2013.

Participation in clinical research

Excellence in research is a priority for the Trust. Without it, there would be no new medicines or tests, or better and even safer ways of providing healthcare—and not just at this hospital, but across the UK.

Participating in research denotes quality care, because it indicates a high level of medical expertise and skill and high standards of care and professionalism. All the research projects at this hospital are carefully regulated and monitored, and carried out with the full knowledge and consent of patients, and in confidence.

In 2012/13 the NIHR$_{G}$ conducted a 'Mystery Shopper' survey to assess the extent to which NHS Trusts were promoting research. 82 NHS Trusts were visited to evaluate how easy it was to find about clinical research opportunities within these organisations. The findings showed that 81% of hospitals did not have information promoting research at their receptions areas or on notice boards, or electronic screens. In general, there was poor response to enquiries about research, and the quality of information on Trust websites was either lacking or varied.

In response to these findings, we have launched a wide scale communication programme to ensure that our patients have access to as much information as possible regarding research that is relevant to them. This has included information for patients on notice boards and patient electronic screens, updating the Trust website to include pages for patients on research and a patient leaflet. There are also regular features in the *Trust News* to ensure patients are kept up to date regarding developments in research and development.

In 2012/13 the number of patients recruited to take part in research that had been approved by a research ethics committee was 1999. The Trust was actively involved in 281 clinical research studies, 149 of which were part of the National Institute for Health Research (NIHR) portfolio. This is a collection of high quality national studies covering a broad range of clinical areas, such as cancer, stroke and paediatrics.

The Trust collaborates with various research partners to ensure its research is responsive to national and local priorities. They include NIHR research networks and local charities such as Westminster Medical School Research Trust and Chelsea and Westminster Health Charity. We also host the NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for North West London, which aims to apply new treatments and approaches to clinical care in the NHS.

CLAHRC has supported five quality improvement projects over the past year at Chelsea and Westminster:

- A comprehensive package of care for all patients with community acquired pneumonia$_{G}$ that is based on the best available evidence (Community Acquired Pneumonia (CAP) care bundle improvement project)

- Improving both the management of patients' medicines during their hospital stay and the information they are given about their medicines when they are discharged (the award-winning Medicines at Discharge project)

- Improving the prescribing of medicines for elderly patients (STOPIT project—see page 54), and introducing the 'My Medication Passport' to help patients manage their own medicines better (see page 53)

- An educational programme for inpatients who have had a stroke or minor stroke (TIA) on what lifestyle changes to make to help prevent it happening again (Stroke PREVEnt project).

- Providing evidence-based care and support for patients admitted with worsening chronic obstructive pulmonary disease (COPD)$_{G}$ to improve their quality of life on discharge from hospital

Other ongoing projects include ground-breaking research looking at how best to curb the person to person spread of HIV infection, using a package of measures (PROUD), and research assessing the impact of ageing on people living with HIV. This last was prompted by the Frontline HIV forum, a patient group at Chelsea and Westminster. One in four patients accessing Trust HIV services is aged 50 and over.

Another research project is looking at how to improve healthcare systems for frail elderly patients who require emergency care at Chelsea and Westminster, by looking in detail at the factors that determine their length of stay in hospital.

At the other end of the age spectrum, researchers at the hospital are testing computer software that analyses the baby's heart rate during labour, in the hopes of being able to use the information to alert doctors to potential problems early on and reduce the risk of complications.

Researchers at the Trust are also working closely with a team at St George's Hospital and investigators in America, to see whether raised blood glucose under stress (stress hyperglycaemia) can uncover undiagnosed diabetes, and how best to treat this poorly recognised condition, which has been linked to a higher risk of death.

The Trust is working closely with Imperial College and Imperial College Healthcare NHS Trust on several areas of research including allergy, COPD, and medicines management. And it is forging stronger links with Imperial College Biomedical Research Centre and the Biomedical Research Units at the Royal Brompton Hospital

Mind the Gap: Improving patient care on the Acute Assessment Unit
Mind the Gap is an initiative on the Acute Assessment Unit (AAU) that is being led by junior doctors and facilitated by NIHR CLAHRC for North West London. It is designed to shorten the time it takes to see and treat patients admitted to the Unit, which often has to cope with extra referrals from Accident and Emergency or GPs.

Based on an approach used in emergency departments, called Rapid Assessment and Treatment, this initiative enables patients to get tests and critical medicines immediately after their arrival on the Unit rather than only after a full medical history has been taken and routine observations made. To prompt early assessment, junior doctors on the Unit developed and tested a simple checklist to be used for every patient on arrival

Mind the Gap aims to close the gap between a patient's arrival and the start of treatment, and proves that a small change can make a big difference to both patients and staff.

For more information on CLAHRC projects please visit www.clahrc-northwestlondon.nihr.ac.uk or contact the CLAHRC office on 020 3315 5966.

What our stakeholders told us they would like to know

From our consultation process and looking at the comments from last year stakeholders told us they wanted to know about the following:

What are the outcomes of the audits on leaflets to patients about waiting times for surgery?

Last year we made significant progress on surgery waiting times and have continued to monitor it—see page 23. We said we would look at information to patients and 'nil by mouth' waiting times this year. We developed and tested a leaflet on waiting times and undertook an audit on whether it was being issued and if patients found it useful.

A snapshot audit showed that although the patients who received the leaflet found it useful the majority of patients had not been offered one (only 22% of the patients we asked). At the time of the audit there were no leaflets in stock—these have been reordered and a named individual made responsible for keeping supplies in stock and encouraging their use.

We looked at the time patients are 'nil by mouth' against the standards of 2 hours for fluids and 6 hours for food and we found that 83% were kept without fluids for more than 4 hours and 71% patients were kept without food for longer than 12 hours. We will reinforce with the relevant staff the need to tell patients when the order of the emergency list changes and whether they can eat or drink. We will check the completion of the emergency surgery booking form in September to ensure that the anaesthetic and surgical teams are communicating the same and correct information to the patients about when they can drink. Then if this is working, we will repeat our checks of the time patients are nil by mouth.

What are we doing about complaints and concerns about appointments and outpatient services?

Last year we said that we would continue to measure complaints and concerns about appointments. Review of the data suggested that it would be more useful to separate complaints and concerns and to classify them in more detail.

Concerns are clustered by theme and actions agreed. For example, concerns were expressed about the appearance of outpatient staff, and as a result, they are now in uniform and wear name badges.

We adopt a more personalised and formal approach to complaints, and they have fallen by 30% over the past year and are continuing to fall. Eight complaints about outpatient services were made between 1 Oct 2012 and 31 Mar 2013. This compares with 15 in the previous two quarters, a fall of 53%.

Many changes have been made to outpatient services over the past year, and to find out what patients thought about them, we held a Patient Experience Workshop in March 2013 where positive and negative patient experiences of care at the Trust were mapped out in

detail. This identified areas of good practice for sharing across the Trust as well as areas where we need to do better.

The feedback from the workshop encouraged us to introduce the 15 Step Challenge[G] from the NHS Institute of Innovation and Improvement in outpatients. The Challenge was sparked by a patient who said '*I can tell what kind of care my daughter is going to get within 15 steps of walking on to a ward*'.

The 15 Steps Challenge focuses on seeing care through a patient's eyes and exploring their first impressions. The Challenge helps staff listen to patients and their carers, and to understand what works well and what needs to be improved.

At Chelsea and Westminster this will involve a small group making spot checks in outpatient areas and recording whether the staff are welcoming and caring, well organised and calm, and whether the information provided to patients is appropriate and helpful. The results will then be fed back to the relevant team so that they can improve the patient experience. These spot checks will be made every other month.

Additionally, all staff who either deal with patients face to face at a reception desk or take patient phone calls will receive customer service training during April and May 2013.

For information about our results in the outpatients survey please see page 61.

We said we would review complaints and concerns around admissions—what have we done and has it improved?

The Surgical Admissions Department deal with all administrative aspects of the patient's elective[G] admission whether as a day case or patients requiring a longer stay at the hospital. We look after the sub-specialties of bariatrics[G], craniofacial[G], general surgery, ophthalmology[G], orthopaedic hands, pain, plastic surgery, trauma and orthopaedics, urology and vascular surgery for adults.

We have very few formal complaints relating to admissions as our aim is to resolve as many as possible by local resolution. However, as part of our ongoing service improvement work we have proactively identified some themes to further improve the patient experience, including resolving difficulties in contacting the admissions team and concerns around waiting times.

To address these we have recently launched a central telephone line for Surgical Admissions. This will make contacting the team a lot easier for the patients and they will always have their calls answered as opposed to leaving messages.

In order to improve our waiting times for elective procedures over the last year we have created extra operating lists for our craniofacial and chronic pain patients who have experienced long waits. We also have a locum pain consultant joining us in the middle of this year, which will significantly help reduce waiting times and access for this group of patients.

We are also currently running a project (Surgical Transformation) which was set up to look specifically at the patient's journey through all parts of the hospital from outpatients, where they are added to the waiting list, through to their admission to hospital for their elective procedure. This project is aiming to make us more efficient and also to improve the patient experience. As a result of this project and the Picker day surgery survey from last year we

identified that one of the common themes was communication to patients. We are currently in the process of reviewing the letters we send to patients regarding their admission, the leaflets and information booklets we provide and access to all of this via the Trust website.

What are we doing about reducing readmission rates?

We have been monitoring readmission rates throughout the year and the discharge team have been working with A&E and wards to support people when they go home and direct them to the most appropriate follow-up services. We have also worked with community colleagues to support patients after discharge, by providing intensive therapies for stroke patients at home, for example.

In late 2012 North West London commissioners scrutinised the number of readmissions to find out why patients were being readmitted to Chelsea and Westminster Hospital as emergencies. They found that less than one in five readmissions could have been prevented, and most of these could have been avoided if enhanced community or social care services had been available.

This reflects well on both A&E and wards, and in particular, it indicates good access to consultants in both areas. But there is more that we can do, and we are considering introducing a multidisciplinary discharge coordination team who will develop a list of community and social service provision and contacts, liaise with GPs, and provide enhanced discharge support for patients.

We have also agreed with commissioners to develop rapid access clinics so that patients who need to be seen quickly can access the appropriate specialist without the need to come to A&E.

What are we doing about helping vulnerable people get their medicines?

Please see page 54 where we describe the work undertaken with Chelsea Pensioners.

We did not do very well in the outpatients survey—what have we done and is it improving?

There have been several developments over the last year which have helped to improve patient experience of our outpatient services. We have built a state-of-the-art facility on the lower ground floor and the plastic surgery and dermatology outpatient services have transferred to a new, purpose built facility.

The new environment has been complemented by using technology to reduce waiting times for check in by using touch screen check-ins and a patient calling system. Free WiFi is provided and we use flat screens in the waiting areas to provide patients with pertinent information.

As part of preparing to move to the new departments we developed an online patient survey, using questions asked in the National Outpatients Survey, to help us target areas we needed to address, monitor improvements and highlight any areas patients thought were working well.

Some of the comments from the survey reflect the positive nature of the improvements to the service and can be seen in the following quotes:

- "being kept informed of the waiting times and the friendliness of the staff made the visit to the hospital less intimidating"

- "the excellent service and the self check-in was fantastic and the staff were really friendly which makes such a difference to the overall experience"

- "very soothing environment with excellent staff"

Although we have seen a significant reduction in the number of complaints and concerns over the last 12 months we are aware a number of patients continue to have a poor experience of outpatients and some of the areas we have been asked to address include:

- Privacy and dignity, particularly in relation to the phlebotomy department where patients have their blood taken in an open area
- Improving ease of communication with outpatients regarding appointments
- Ability to book and reschedule appointments on line
- Fragmented communication across departments involved in outpatient services
- Staff attitude and staff available to respond to issues patients may experience

We value the feedback we have from patients and are taking steps to address all concerns raised.

Towards the end of this year we will be relocating the phlebotomy department to the new lower ground floor which will provide individual rooms for taking blood from all patients. During the course of this year we will be replacing our appointment scheduling system so that patients will be able to book, confirm and reschedule appointments online. It will allow us to improve how we communicate with patients, store any preferences patients may have for how we communicate with them and join up communications Trust wide. It will also allow more efficient clinic management, reducing unnecessary cancellations and short notice appointments which we know is extremely inconvenient for patients. We will be developing our customer service training and introducing a "First Impression Programme" alongside a more visible management presence in the outpatients department.

What is the outcome of the re-audit of approval to operate/anaesthetise?

In the last Quality Report we said that since June 2011 the responsible consultant surgeon/consultant anaesthetist must approve the decision to operate/agree the anaesthesia to be used before the patient is booked for surgery. An audit showed that this is documented in around half of cases. This senior level input was already happening for complex cases but we wanted to make sure it was happening for all cases. This senior level input into the booking process helps prioritise surgery and communication and ensures awareness of what surgery is taking place, which is particularly important for complex cases and those requiring surgery out of hours. We said that we were re-enforcing the importance of this practice and the theatre team has been reminded that a case cannot be booked unless consultant agreement has been obtained and the documentation completed. We will re-audit in September 2012. Since then there has been a change in the lead for emergency surgery anaesthesia and the delay before re-appointment meant that an audit to check effectiveness of this process was delayed and results are awaited.

What are the plans for the PALS service?

The PALS service helps patients navigate through their hospital experience providing them with assistance but also helping them with concerns that are easily resolved—more complex concerns are registered as complaints. PALS attend staff meetings and provide teaching programmes in clinical areas to provide advice on how to address issues early

We would like to focus on strengthening our approach to addressing issues at the time they are raised and by the right person in the right place. An evaluation of the current service will be taken forward during the coming year.

How will the 'Safety Thermometer' be taken forward?

The NHS Safety Thermometer is a tool for measuring patient safety that was introduced in April 2012.

The tool is used to collect information relating to some key harm factors for each patient and includes VTE, pressure ulcers, falls and ureteral catheter infections. On a set day each month, every current inpatient is assessed for the presence of any of these harms and the results are recoded on a central database. This allows us to monitor the prevalence of these harms and to assess our performance in providing harm-free care. A key focus for the forthcoming year will be reducing harm associated with pressure ulcers. As we develop further our reporting we will use this to provide ongoing feedback to the relevant wards.

What are we doing about the 6Cs for nursing?

A new compassionate caring vision for nurses has been launched by the Chief Nursing Officer for England. The vision is based around six values—care, compassion, courage, communication, competence and commitment. The vision aims to embed these values, known as the Six Cs, in all nursing, midwifery and care-giving settings throughout the NHS and social care to improve care for patients. We have aligned this vision and related objectives to our Trust values and to our strategic nursing objectives for the forthcoming year.

Valuing our workforce

The seven staff pledges in the NHS Constitution (revised in February 2013) will help create and maintain a highly skilled and motivated workforce capable of improving the patient experience.

Pledge 1: To provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability;

Our 2012 staff survey shows we have positive staff engagement and remain in the top 20% of all acute Trusts nationally, as reported in the NHS staff survey.

Pledge 2: To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities

The Trust was in the top 20% of acute Trusts for the 2012 NHS staff survey. Key Findings[G] relating to % of staff feeling satisfied with the quality of patient care they deliver, % agreeing their role makes a difference to patients, level of work pressure felt by staff, effective team working, % of staff receiving relevant training, having well-structured appraisals and receiving support from their immediate managers; % of staff reporting errors or near misses, and the fairness of reporting procedures for these incidents, % of staff feeling pressure to attend work while unwell, % of staff able to contribute towards improvements at work, staff recommendation of the Trust and staff job satisfaction.

Pledge 3: To provide all staff with personal development, access to appropriate education and training for their jobs and line management support to enable them to fulfil their potential

The 2012 staff survey results showed that 82% of staff had an appraisal and a personal development plan based on their objectives in the previous 12 months. The results also show the Trust is in the top 20% of acute Trusts for its quality of appraisals (staff having a well-structured appraisal)

The Trust offers more than 100 different training courses including a range of leadership courses accredited by the Institute of Leadership and Management. Other programmes designed to improve the quality of staff development including educational supervision for clinical staff, coaching, appraisal, Neuro-Lingustic Programming and Emotional Intelligence.

All new staff attend the Trust's corporate induction, which includes a session led by the Chief Executive explaining the Trust's objectives and core values, our approach to quality, and what role staff can play in this. We improved our score in the NHS staff survey relating to staff receiving training, learning or development relevant to their job from 83% to 85% in 2012 and are above average for acute Trusts and highest in London's acute Trusts.

However, for mandatory training[G] which is a sub-set of job relevant training, we had an overall compliance of 73% in attendance at mandatory training courses as at the end of March 2013. Our target is to achieve 95% and compliance is increasing but at a slower rate than anticipated. In order to improve compliance a number of actions have been agreed including ensuring that staff know exactly what induction and update training they need to do, simplifying the guidance and access to e-learning courses, scheduling staff centrally and automatically into induction and updates and linking pay progression to mandatory training compliance. This will continue to be a major focus for us in 2013/14.

We have a comprehensive ward manager development programme and a clinical leaders' programme in partnership with the NHS Institute for Innovation and Improvement.

Evaluations of all nursing and professions allied to medicine student placements are carried out by qualified trainers and results are fed back to the Trust by the various universities at the end of each academic year. This feedback guides further change, as appropriate, as well as ideas for further development and this year we have a new director and board for our education and training.

Pledge 4: To provide support and opportunities for staff to maintain their health, well-being and safety

We provide occupational health support to our staff and also run regular health and wellbeing events for staff which include mini health MOTs, health and safety awareness sessions and weekly subsidised yoga classes. We have also improved facilities for staff that cycle to work.

Additionally, we provide a wide range of access to wellbeing support such as:

- fast-track musculoskeletal physiotherapy services
- specialist counselling and advisory services
- stress management courses in areas where levels of stress are highest

Sickness absence levels have reduced to an average of 3.72% in 2012/2013. The Trust has been named in the Top Employers for Working Families Awards from 2010 to 2012 and has been awarded the Best for Carers' and Eldercare Award in 2012. We also launched a new 'Benefits and Wellbeing Newsletter' in early 2013 to promote the wide range of benefits and support available for staff.

Pledge 5: To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families

We have well-established methods of involving staff, including joint consultative frameworks and strong lines of communication. The NHS staff survey results show that the Trust's performance in both communication and staff engagement has improved every year for the past three years.

Pledge 6: To have a process for staff to raise an internal grievance

We have a Trust Grievance Policy in place that is jointly reviewed and agreed with our staff side representatives on a regular basis.

Pledge 7: To encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Public Interest Disclosure Act 1998.

All our policies and practices are focussed on early resolution to providing the right environment for staff to be able to raise and address concerns early on. We have a Policy for Raising Concerns (Whistleblowing) and actively encourage and engage with staff to discuss issues in an open environment for the safety and welfare of our patients, their care and our staff.

Putting staff in the driving seat

The Trust recognises that our staff are a valuable resource and have a key role in contributing to helping the NHS make the required substantial savings, while still maintaining and improving the quality of services. But for that to happen, staff need to be fully involved. We have therefore taken a strategic approach to this, and used a range of approaches. These include:

- open staff forums about key challenges facing the Trust
- giving staff opportunities to come up with ideas to improve quality or efficiency, such as the Directors' Den initiative
- monthly team briefings, the *Trust News* staff magazine (monthly), Daily Noticeboard email bulletin, and weekly e-newsletters for specific initiatives to promote an open and transparent culture
- continuing work on embedding our Trust Values and behaviours has positively influenced the organisation
- celebrating the achievements of staff—the Council of Governors Quality Awards recognise the contributions that individuals or teams make to improving the quality of patient care (see page 67), and the Chelsea and Westminster Star Awards recognise the work of both clinical and non-clinical staff

The Trust was rated the best acute Trust nationally for good communication between senior managers and staff in the 2012 NHS staff survey.

Fast track service for staff with aches, pains, and sprains

Pain in back, neck, shoulders, or arms and hands can be a sign of a musculoskeletal (MSK) disorder. These disorders affect muscles, joints, tendons, ligaments and nerves, and are responsible for millions of days taken as sick leave every year in the UK.

Staff at Chelsea and Westminster with MSK problems, which affected their ability to work, used to have to wait an average of 10 days for an assessment by the Occupational Health Service, and then another 10 days if they needed physiotherapy.

During this time, staff often could not work at full capacity or at all, which inevitably affected patient care. Evidence shows that the quicker people with MSK problems receive physiotherapy, the greater are their chances of making a full recovery.

A fast track service for staff was therefore put in place. Managers can now directly refer a member of staff to the MSK physiotherapy service, as early as the day of injury/start of symptoms for treatment. This can start within 48 hours if the problem is directly affecting their ability to work or sleep.

This rapid access to therapy means that staff resume full work duties much more quickly than before, and they minimise their chances of developing persistent problems. This new service is highly valued by staff.

A survey in 2012 of those who had used the service revealed that around 80% of clinical staff and managers gave the service full marks. And more than half of those treated said they would have had to reduce their workload or take more time off sick if they had not been fast tracked.

Quality Awards

The Council of Governors Quality Awards aim to recognise and reward contributions to quality initiatives in the Trust by an individual or team under the three quality areas that are key to delivering high quality care: patient safety; patient experience; and clinical effectiveness.

Applicants have to prove that they also meet the Trust values of safe, kind, excellent and respectful, and show how their initiative could be applied elsewhere in the Trust to boost the quality of patient care.

The awards, which have been running since January 2011, are open to all staff as every employee has the potential to improve quality either directly or indirectly.

Winners have the opportunity to meet directly with key Trust directors and governors from the Council of Governors Quality Sub Committee to discuss their initiatives and highlight the value of their achievements.

In 2011/12, awards were made in the Spring and Autumn.

Spring Award winners

- The Decontamination Services Department—Clinical Support Services Division—for significantly improving endoscopy decontamination services in the Trust.

- The Medihome Team—Medicine and Surgery Division—for providing care to patients in their own home and preventing the need for some patients to be admitted to hospital.

- The Power Works Team—Corporate Services Division—for their contribution to patient safety during extensive refurbishment at the hospital.

- West London African Women's Service and the West London Centre for Sexual Health—Women's, Children's, Sexual Health and Dermatology Division- for its joint dedication to improving the care of women who have experienced genital mutilation—the first of its kind.

Spring commended winners

- Coffee morning drop-in sessions for parents on the Neonatal Unit
- Members of the Chaplaincy Multi-faith Team
- Improving care for pregnancy related pelvic girdle pain
- Women's and Men's Health Physiotherapy Team
- Improving medication at discharge: Closing the Loop project
- CLAHRC (Collaboration for Leadership in Applied Health Research & Care) Project Team
- VTE exemplar status
- VTE Risk Assessment Development Team, IT, data warehouse and clinical representatives
- Hand therapy service improvements
- Hand Therapy Team

- Nutritional screening
- Dietetics Team
- Nutritional status of hospital patients
- Nutritional Screening Group
- HIV neurocognitive$_G$ screening
- HIV Neurocognitive Screening Team
- Improved birth experience
- Anne Steward Ward, Maternity Unit
- Hip fracture care improvements
- Orthopaedic Nurse Specialist and the Hip Fracture Multidisciplinary Team

Autumn Award winners

- The Palliative Care Team—Medicine and Surgery Division—for their rapid discharge pathway for terminally ill patients who wish to die at home

- Friends Patient Support Project—Corporate Services Division— for volunteer led initiatives to reduce the loneliness, social isolation, and poor nutrition of patients, particularly the elderly and vulnerable: patient visiting service, mealtime assistance, Here to Help service, the Time Out service and the By Your Side service.

- A&E—Medicine and Surgery Division—for improving the patient experience by reducing waiting times, improving communication and meeting clinical quality indicators

- The Maternity Team—Women's, Children's, Sexual Health and Dermatology Division—for supporting women better in early labour and after birth with the provision of The Nest, comfort rounds, and infant feeding volunteers; improved postnatal ward efficiency; the provision of a birth afterthoughts midwife to discuss difficult experiences and raise concerns; better representation of local families and the public on the Maternity Services Liaison Committee and campaigns to raise the public profile of the service.

- The Musculoskeletal Physiotherapy Department— Clinical Support Division—for developing the Rapid Access Occupational Health Physiotherapy Service to enable staff to receive prompt treatment and advice and return to work more quickly

- The Centre for Clinical Practice—Corporate Services Division— for ensuring that training meets local and national requirements

Autumn commended winners

- Carpal Tunnel one stop diagnostic clinic
- Carpal Tunnel Clinic Team
- Medical Day Unit
- Medical Day Unit Team
- Nurse Champion: A collaborative approach to embedding quality improvement initiatives
- Acute Admissions Unit

Our physical environment

Chelsea and Westminster is a modern, well-designed hospital, but the physical environment needs to be able to respond to changes in service provision. The Trust is

continuing its multi-million pound investment programme to maintain and improve its facilities and meet rising demand for services

Recent developments include:

- A dedicated Children's Burns Unit, which opened in January 2013
- A Diagnostics Centre, which brings together endoscopy, cardiology, and associated services: the £3 million unit opened in March 2013
- Locating the dermatology and plastic surgery departments within a single, refurbished unit
- Conclusion of the £9.8 million upgrade to the hospital's energy and resilience infrastructure to make it safer, more energy efficient and better value for money
- Completion of the first year of a three-year programme to replace flooring throughout the hospital
- A comprehensive upgrade of the hydrotherapy pool
- Upgrades to the hot water and security access control systems
- Refurbishment of public and staff washroom facilities

A five-year development plan is under way which will ensure that the Trust has state-of-the-art facilities to meet the needs of all its patients. Plans include:

- An improved and expanded A&E Department for both adults and children
- Increased capacity for adult admissions
- Ongoing improvements to adult outpatient areas
- A midwifery-led unit, bringing together maternity and women's services on the third floor

Equality and diversity

The Single Equality Scheme was replaced by a new set of equality objectives in April 2012, following the passage into law of the Equality Act 2010. These objectives set out the Trust's approach to equality and diversity, both as a provider of quality health care and as an employer. They aim to:

- Improve the collection and use of equality related data across the organisation to inform decision-making or improve a service eg recording and analysing complaints and patient or workforce data by protected characteristics$_G$ will help us understand the needs of our staff and patients.

- Continue to develop and promote an organisational culture that supports the principles of equality

- Effectively communicate with, engage, and involve all of our stakeholders in equality

- Strengthen equality and diversity communications and resources across the Trust to increase staff awareness and knowledge of different equality related topics.

The Trust Equality and Diversity Steering Group$_G$ will monitor progress against each objective.

Examples of good equality and diversity practice in action at the Trust in 2012/13 include the provision of a sexual health clinic (ClinicQ) for those whose personal sense of their gender identity and/or gender expression differs from their assigned sex at birth (transgender men and women) and the refurbishment of the David Erskine Ward to be

'dementia friendly$_{G}$.' The Trust also continues to focus on how to improve the experience of patients with learning disabilities.

Examples of good equality and diversity practice for staff in 2012/13 included holding a staff seminar to raise awareness of sexual orientation equality in the workplace, and holding staff listening groups to embed the Trust's 'respectful' value.

Quality looking forward

Quality is central to everything we do at Chelsea and Westminster and is reflected in our Trust values of safe, kind, excellent, and respectful.

Good quality healthcare care depends on getting the basics right. That means providing safe and effective care in a clean and pleasant environment. And it means making patients feel welcome and confident that they will be treated with dignity and respect.

We believe that receiving the right care, in the right place, at the right time by well-trained staff is every patient's basic right. But the publication of the independent review of Mid Staffordshire Hospitals NHS Foundation Trust ('The Francis Report') in February 2013 shows that unless an organisation's systems and processes are closely scrutinised and its leadership roles clearly defined, serious mistakes and poor practice can escape detection.

Therefore, this year continued emphasis will be placed on understanding our culture, systems and processes in greater detail and what we can learn from the Francis Report.

We will therefore develop a quality strategy to provide us with a framework for making measurable service improvements and delivering a patient experience that is unsurpassed. Above all, the strategy will help us realise our goal of becoming one of the safest and most effective organisations in healthcare.

Part 4

Our performance

Our performance on key national priorities 2012/13

The Trust met all the national priority targets tracked by Monitor, the independent regulator of Foundation Trusts.

Indicator	Target	2012/13 Performance
Incidence of *Clostridium difficile*	31	Achieved
Incidence of MRSA bacteraemia	6	Achieved
All cancers: 31-day wait from diagnosis to first treatment	96%	Achieved
All cancers: 31-day wait for second or subsequent treatment: surgery	94%	Achieved
All cancers: 31-day wait for second or subsequent treatment: anti cancer drug treatments	98%	Achieved
All cancers: 62-day (urgent GP referral to treatment) wait for first treatment	85%	Achieved
All cancers: 62-day wait for first treatment from consultant screening service referral	90%	Achieved
Cancer: two week wait from referral to date first seen comprising all cancers	93%	Achieved
Referral to treatment waiting times—admitted	<23 weeks	Achieved
Referral to treatment waiting times—non-admitted	<18.3 weeks	Achieved
A&E: Total time in A&E	≤4 hours	Achieved
A&E: Time to initial assessment	≤15 minutes	Achieved
A&E: Time to treatment decision	≤60 minutes	Achieved
A&E: Unplanned re-attendance rate	≤5%	Achieved
A&E: Left without being seen	≤5%	Achieved

Indicator	Target	2012/13 Performance
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliant	Achieved

Our performance on mandated indicators

The following data outlines the Trust performance on selected National Framework Indicators. The data source is the Health and Social Care Information Centre.

Indicator	Most recent data available	Performance				Action taken or to be taken if applicable
		Trust	National Average	Best in England	Worst in England	
Summary hospital-level mortality indicator ("SHMI")	Apr11–Mar12	0.73	1	0.71	1.24	The Trust is in the top 10% of all Trusts and will seek to maintain this
	Jul11–Jun12	0.77	1	0.71	1.25	
Patient deaths with palliative care coded	Apr11–Mar12	16.1%	18.09%	n/a	n/a	The Trust undertook an audit on mortality coding in 2012/13 and will continue work in 2013/14 to assure on mortality coding accuracy
	Jul11–Jun12	16.1%	18.60%	n/a	n/a	
Patient reported outcome measures scores for groin hernia surgery	Apr11–Mar12	0.052	0.087	0.143	-0.002	The Trust is worse than the national average. Pre-operatively it was identified that the survey was being completed on the day of surgery which is not optimal. Action taken to improve our position was to have the survey done in pre-assessment instead. Post operatively the Trust needs to make sure analgesia is in line with enhanced recovery protocol.
	Apr12–Sep12	Not available because of low volumes	0.091	0.158	0.017	n/a
Patient reported outcome measures scores for varicose vein surgery	Apr11–Mar12	0.056	0.094	0.167	0.047	The Trust is worse than the national average. Pre-operatively it was identified that the survey was being completed on the day of surgery which is not optimal. Action taken to improve our position was to have the survey done in pre-assessment instead. Post operatively the Trust needs to make sure analgesia is in line with enhanced recovery protocol.
	Apr12–Sep12	Not available because of low volumes	0.093	0.138	0.024	n/a
Patient reported outcome measures scores for hip replacement surgery	Apr11–Mar12	0.417	0.416	0.532	0.306	The Trust is worse than the national average. Pre-operatively it was identified that the survey was being completed on the day of surgery which is not optimal. Action taken to improve our position was to have the survey done in pre-assessment instead. Post operatively the Trust needs to make sure analgesia is in line with enhanced recovery protocol.

Indicator	Most recent data available	Performance				Action taken or to be taken if applicable
		Trust	National Average	Best in England	Worst in England	
	Apr12–Sep12	Not available because of low volumes	0.437	0.502	0.333	n/a
Patient reported outcome measures scores for knee replacement surgery	Apr11–Mar12	0.238	0.302	0.385	0.18	The Trust is worse than the national average. Pre-operatively it was identified that the survey was being completed on the day of surgery which is not optimal. Action taken to improve our position was to have the survey done in pre-assessment instead. Post operatively the Trust needs to make sure analgesia is in line with enhanced recovery protocol.
	Apr12–Sep12	Not available because of low volumes	0.312	0.387	0.244	n/a
Readmitted to the Trust within 28 days of being discharged from hospital (Age 0–14)	Apr10–Mar11	8.57%	10.15%	0%	128.16%	The Trust is better than the national average. The Trust continues to work on discharge support for parents and with community partners to maintain low rates of readmission.
	Apr09–Mar10	7.33%	10.18%	0%	76.29%	
Readmitted to the Trust within 28 days of being discharged from hospital (Age 15+)	Apr10–Mar11	11.47%	11.42%	0%	53.31%	The Trust is marginally worse than the national average. The Trust continues to work on discharge support for parents and with community partners to maintain low rates of readmission.
	Apr09–Mar10	11.47%	11.16%	0%	42.2%	
Responsiveness to the personal needs of its patients	Apr11–Mar12	63.7	67.4	85	56.5	The Trust is worse than the national average and there is an action plan in place for all areas of the inpatients survey where the Trust is worse than average.
	Apr10–Mar11	64.7	67.3	82.6	56.7	
Staff employed by, or under contract to, the Trust who would recommend the Trust as a provider of care to their family or friends.	Jan11–Dec11	80%	65%	96%	33%	The Trust is significantly better than average and will work to be one of the top performers
	Jan10–Dec10	n/a	n/a	n/a	n/a	
Patients who were admitted to hospital and who were risk assessed for venous thromboembolism	Oct12–Dec12	93.3%	94.1%	100%	84.6%	The Trust met the target for 2012/13 and will be working towards the revised target for 2013/14
	Jul12–Sep12	92.6%	93.8%	100%	80.9%	
Rate per 100,000 bed days of cases of *C.difficile* infection reported within the Trust amongst patients aged 2 or over	Apr11–Mar12	14.8	21.8	0	51.6	The Trust will continue to work towards meeting our target of no more than 13 cases which is equivalent to a rate of 9.47 per 100,000 beds days
	Apr10–Mar11	63.6	29.6	0	71.8	The Trust reduced this rate considerably for subsequent years
Rate of patient safety incidents reported within the Trust and the number and percentage of such patient safety incidents that	Oct11–Mar12	2,482 incidents; 6.93 incidents per 100 admissions; Nil resulted in severe harm or death	4,651 incidents; 6.92 incidents per 100 admissions; 31 incidents resulted in severe harm or death; 0.05 resulted in severe harm or death	7,498 incidents; 21.71 incidents per 100 admissions; 144 incidents resulted in severe harm or death; 0.5 resulted in severe harm or death	451 incidents; 0.94 incidents per 100 admissions; Nil resulted in severe harm or death	The Trust is working on increasing the incident reporting rate to be in the top centile while having no incidents resulting in severe harm or death

Indicator	Most recent data available	Performance				Action taken or to be taken if applicable
		Trust	National Average	Best in England	Worst in England	
resulted in severe harm or death (see note below)	Apr11–Sep11	2,364 incidents; 6.60 incidents per 100 admissions; 3 incidents resulted in severe harm or death; 0.01 resulted in severe harm or death	4,400 incidents; 6.63 incidents per 100 admissions; 28 incidents resulted in severe harm or death; 0.05 resulted in severe harm or death	3,999 incidents; 19.25 incidents per 100 admissions; 110 incidents resulted in severe harm or death; 0.35 resulted in severe harm or death	2,421 incidents; 2.13 incidents per 100 admissions; Nil resulted in severe harm or death	

Chelsea and Westminster Hospital NHS Foundation Trust considers that this data is as described for each indicator because The Trust has robust data quality assurance processes in place.

Note: Patient safety indicators resulting in severe harm or death

This year is the first time that this indicator has been required to be included within the Quality Report alongside comparative data from the Health and Social Care Information Centre. The National Reporting and Learning Service (NRLS) was established in 2003. The system enables patient safety incident reports to be submitted to a national database on a voluntary basis designed to promote learning. It is mandatory for NHS trusts in England to report all serious patient safety incidents to the Care Quality Commission as part of the Care Quality Commission registration process. To avoid duplication of reporting, all incidents resulting in death or severe harm should be reported to the NRLS who then report them to the Care Quality Commission. Although it is not mandatory, it is common practice for NHS Trusts to reports patient safety incidents under the NRLS's voluntary arrangements.

As there is not a nationally established and regulated approach to reporting and categorising patient safety incidents, different trusts may choose to apply different approaches and guidance to reporting, categorisation and validation of patient safety incidents. The approach taken to determine the classification of each incident, such as those 'resulting in severe harm or death', will often rely on clinical judgement. This judgement may, acceptably, differ between professionals. In addition, the classification of the impact of an incident may be subject to a potentially lengthy investigation which may result in the classification being changed. This change may not be reported externally and the data held by a trust may not be the same as that held by the NRLS. Therefore, it may be difficult to explain the differences between the data reported by the Trusts as this may not be comparable.

Local performance indicators

Our performance on local quality indicators 2012/13

Subject	2008/09	2009/10	2010/11	Performance 2011/12	Target 2012/13	Performance 2012/13	Target 2013/14	Comment
Patient Safety								
MRSA$_G$ bacteraemia cases	5	10	6	2	2	1	0	These targets are those set by the Department of Health
C.difficile$_G$ cases	41	32	73	17	31	15	13	These targets are those set by the Department of Health
Hand hygiene audit—% completion rates$_G$	57.7	71	89	94	100	96	100	Although we did not meet the target we have improved slightly compared with 2011/12

Subject	2008/09	2009/10	2010/11	Performance 2011/12	Target 2012/13	Performance 2012/13	Target 2013/14	Comment
Hand hygiene—% compliance rates[G]	77	80	85	94	95	95	95	
Inpatient falls per occupied 1,000 bed days[G]				3.19 (cumu. rate reported at the end of 2011/12)	3	2.62	3	Last year we said we would focus on all inpatient falls and measure falls per 1,000 occupied bed days. We have replaced 'patient falls resulting in moderate or major harm' with this indicator. This is because this indicator allows for changes in activity and there is a national benchmark. Also there is limited control over whether a fall causes harm or not and the best way to reduce harm is to reduce falls overall.
Patient safety incident reporting rate—incidents per 100 admissions	6.6	7.1	7.1	6.6	8	6.7	8	We have clarified that this refers to patient safety incidents rather than total incidents. Online reporting was delayed but will be introduced this year and this should increase the reporting rate. Data is from April—Sep 2012 from the NPSA National Reporting and Learning System (NRLS)[G]. See below – this data have been retained within the account to allow comparison year on year.
Number and rate of patient safety incidents reported within Trust (number per 100 admissions)				Number = 4,998 Rate = 6.5	8	Number = 5,162 Rate = 6.7	8	This is local data for a full year whereas the data above is from the NRLS and is for 6 months.
Number of patient safety incidents resulting in severe harm or death and % of total incidents				2 which is 0.04% of total incidents	0	3 which is 0.06% of total incidents	0	Local data – new indicator
Never Events[G]				5	0	3	0	See page 44. Data from local incident reporting system.
% of adult inpatient (excluding maternity) observation charts scored accurately (CEWSS)[G] (see note 1)	56	68	81	89	85	Not measured		See below
Resuscitation calls (cardiac arrest) due to failure to escalate				7	5	2	5	This measures whether doctors are being called appropriately when patients begin to deteriorate resulting in a cardiac arrest call. The numbers are low and therefore a % reduction was not considered appropriate. There is no national definition for this indicator. The target has been kept at 5 as we will be introducing the national early warning system and the impact is unclear.
% patients with International Normalised Ratio (INR) less than 5	No data	98 (Aug–Dec 2010)	97	97	96	97	96	INR is a measure of the ability of the blood to clot

Subject	2008/09	2009/10	2010/11	Performance 2011/12	Target 2012/13	Performance 2012/13	Target 2013/14	Comment
Hospital acquired preventable cases of venous thrombo-embolism (VTE)				10 (7 months data)	13	13	10	Numbers relate to cases judged to have been preventable after a root cause analysis. Our ultimate target will remain as zero and we plan to reduce by a further 25% in 2013/14 as part of our aim to have no hospital associated preventable VTE events.
Clinical Effectiveness								
Mortality (Hospital Standardised Mortality Indicator—HSMR)$_G$	86.2%	80.8%	75.80% (taken from Dr Foster Apr 2010–Jan 2011)—this was 85% for the whole year	71.39% (taken from Dr Foster Apr 2011–Jan 2012)	71%	81.39		The target is to remain in the 10% of hospitals with the lowest HSMR and we met this target based on April 12 to Jan 13 data—data source Dr Foster.
Mortality (Summary Hospital-level Mortality Indicator—SHMI)$_G$	Q2 to Q4 2008/09 was 79.37%	85.1%	78.1%	Only Q1 and Q2 data available—73.83%	77%			The target is to remain in the top10% of hospitals with the lowest SHMI and we met this target based on Oct 11 to Sep 12 data—data source Dr Foster.
% urgent surgery cases operated on within 24 hours of booking		94 (avg of Dec 2009 and Mar 2009 data)	99 (avg of Nov 2010 to Mar 2011 data)	95	100	98	100	While we will always work towards a target of 100% we have set ourselves a tolerance limit of greater than or equal to 90%. There is no national definition for this indicator
% expedited surgery cases operated on within 4 days of booking		94 (avg of Dec 2009 and Mar 2009 data)	95 (avg of Nov 2010 to Mar 2011 data	99	100	100	100	While we will always work towards a target of 100% we have set ourselves a tolerance limit of greater than or equal to 90%. There is no national definition for this indicator
Urinary catheters continuing care—% compliance with Care bundles$_G$				92	90	92	90	This was a new indicator in 2011/12
Central line continuing care—% compliance with Care bundles$_G$				90	100	94	100	We continue to work towards achieving 100% compliance.
Peripheral line continuing care—% compliance with Care bundles$_G$				86	90	80	90	We set ourselves an aim to be 90% by Mar 2012 and maintain that. We did not meet this target. We will focus on the main reasons which are not labelling the IV lines and not documenting dates in notes.
Numbers of hospital pressure ulcers—grade 2$_G$ (see note 2)			120	47	n/a	70	35	
Numbers of hospital pressure ulcers—grades 3 and 4$_G$ (see note 2)			58	31	n/a	38	8	There were 17 grade 3 ulcers and 21 grade 4 ulcers. These will be measured separately in 2013/14. The target for grade 4 will be zero and for grade 3 a 50% reduction ie 8

Subject	2008/ 09	2009/ 10	2010/ 11	Performance 2011/12	Target 2012/13	Performance 2012/13	Target 2013/14	Comment
% patients nutritionally screened on admission$_G$ (see note 3)	40	60	80	95	90	85	90	Up until October 2012 we were achieving 90% of our patients receiving a nutritional screen on admission and 89% of patients were being re-screened weekly. However, a new electronic system was installed in November 2012 and some teething problems meant that the data collection was not completed fully in the months from November to March 2013. This has affected our overall figures. However this is now resolved and from April 2013 we are expecting to regain our 90% target.
% patients in longer than a week who are nutritionally rescreened (see note 3)	0	10	30	60	90	71	90	See above
Patient Experience								
% complaints reopened		10	9	4	5	5	6	The % reopened could change if we receive notification at a later date that a complainant is unhappy. There is no national definition for this indicator.
Complaints upheld by the Ombudsman (PHSO)$_G$				0	0	0	0	During the year 2012/13 the PHSO considered nine complaints. For one, the Trust was asked to undertake further local resolution meeting, in eight no further action was taken.
% Complaints responded to within target time (formal complaints responded to in 25 working days)	92	83	83	80	90	81	90	We have now initiated weekly reviews of all complaints that are due in order speed up responses.
Complaints (type 1 and type 2)—communi-cation			260	198	178	145	n/a	We achieved our planned reduction of 10%. However, in order to measure against our objective relating to compassion, we are breaking down our complaints about communication further so that we can measure complaints relating to attitude and behaviour separately. We will aim to reduce each category by a further 10% next year. There is no national definition for this indicator.
Complaints (type 1 and type 2)—discharge			108	49	50	32	28	We wish to achieve a further 10% reduction. There is no national definition for this indicator.
Complaints (type 1 and type 2)—older people				110	88	81	n/a	We plan to replace this in 2013/14 with an indicator to measure compassion—complaints about attitude and behaviour.
PEAT Scores$_G$	E for food and environ-ment$_G$ for privacy and dignity	E for all	E for all			E for all	E for all	A visit by the Commissioners on 17 July 2012 gave a rating of Excellence for PEAT Scores. This is to be replaced by Patient Led Assessment of the Care Environment (PLACE)

The data above is collected locally and according to national definitions unless indicated otherwise.

Notes

1. Scoring of observation charts (CEWSS)
The 6 monthly audit was due in September 2012 but at that time it was agreed to implement the new national early warning system (NEWS) and resources were directed towards implementing the new system. In February—a pilot of the NEWS was undertaken on two wards which has resulted in some changes to the NEWS observation charts. NEWS is taking longer to implement than was initially planned and CEWS audits are being undertaken in the meantime.

2. Pressure ulcers measurement
See Clinical Effectiveness section on page 45 for further information. We said last year that we were introducing an electronic way to record pressure ulcers in 2012/13 to improve the accuracy and ease of recording and will be setting our target based on these figures. We discovered that this is less reliable than the reporting of clinical incidents and so we continued to monitor based on clinical incident reporting data as this appears to be the most reliable.

In addition, a new classification was introduced in December 2012. We now use grades 1–4 and have added unstageable. When counting and reporting unstageable ulceration we will count this along with grade 3 ulcers. This category is attributed when we are unable to see the true extent of the ulceration, ie where the skin is black or the wound is covered with dead tissue. We then re-grade the damage when the true extent is evident. We have found that many of the ulcers previously graded as stage 4 have subsequently been less severe; often grade 2 or 3. This change in categorisation is in line with that of other London hospital Trusts and therefore enables us to compare ourselves with others. We were disappointed to note an increase in pressure ulcers although we feel some of the increase is due to increased awareness and therefore reporting. We have set ourselves a target to reduce by 50%.

3. Nutrition
Last year we said we would look at weighing patients to test if this is a helpful measure of how well we are feeding our patients.. We have measured weight on admission and discharge for all patients vulnerable to malnutrition and found that 29% gained weight of an average of 6%, there is no national benchmark or average, so we are unable to compare this with other hospitals. We continue to focus on optimum nutrition for patients and are working on improving our overall nutrition pathway systems with introducing a high energy and high protein menu from April 2013 and will be re-auditing the results again this year for comparison.

Part 5

Statements relating to quality of NHS services provided

Statements of assurance from the Trust Board

During 2012/13 Chelsea and Westminster Hospital NHS Foundation Trust provided and/or subcontracted 78 NHS services. The Trust has reviewed all the available data on the quality of care for all of these services.

The income generated by the NHS services reviewed in 2012/13 represents the total income generated from this source by the Trust for 2012/13.

How the Trust reviews its services for quality

The Trust has systems and processes in place to ensure that data on quality and quality improvement are regularly reviewed. These reviews enable us to pick up on issues that warrant further attention, track the progress of any investigations we might need to carry out as a result, and follow up on any changes made to improve processes/services.

Specific quality reports for each of the Trust's three clinical divisions are issued quarterly so that they can be included in overall performance reviews. The reports include information on:

- Complaints and concerns
- Patient safety incidents (mistakes)
- Legal claims
- New cases of hospital associated infections (MRSA$_{G}$ and *Clostridium difficile*$_{G}$)
- Hand hygiene of medical and nursing staff
- Clinical guideline updates
- Mandatory staff training
- Participation in clinical audits (which collect information on treatment and its impact)
- Research projects
- Actions taken to minimise harm (risk register) for the organisation and patients

The results of audits carried out across the Trust in areas such as record-keeping and consent are also fed back to each of the three divisions.

Patient experience is a priority for the Trust, and each division has a clear action plan for this, with activity in this area reported to the Patient and Staff Experience Committee.

Other checks and balances are provided by:

- The Trust Executive Quality Committee, the most senior management level committee within the Trust which has a specific remit to look at quality

- The Assurance Committee, a sub-committee of the Trust Board

It is very important that we assess quality for patients directly and we do this in a number of ways. This is explained in more detail on page 50—Measuring what matters measuring at the front line.

Business planning

Our business planning process, gives us the opportunity to help our clinical divisions and corporate departments set priorities so that they can provide an excellent and safe service delivered with kindness and respect, in accordance with our Trust values.

This planning process is linked to the annual review of contracts with commissioners and provides a basis for subsequent quarterly performance review meetings, held throughout the year, between the clinical divisions and the Executive team.

During this year's planning process we consulted widely with our governors, senior clinicians and managers, and other parties such as the local and specialist clinical

commissioners, and the local Health and Wellbeing Boards[G] to gain a clear understanding of local and national health system priorities.

Key areas include the continued push to develop primary care and community services, avoid emergency admissions and readmissions, improve discharge planning and aftercare, and develop excellent specialist services.

We have assessed quality in each clinical division to see what works well and what needs to work better, so that we can set priorities accordingly. And we have estimated the demand for our services and our capacity to deliver, so that we can make sure we respond to need promptly and safely.

We work in an environment of financial pressure at the moment, and we have to save the equivalent of 4% of our income. But quality of care remains our primary concern, so we have introduced a formal quality assessment of each proposal to save money to ensure that it does not undermine patient care or safety.

Taking part in clinical audits

Clinical audits collect information on the treatment patients receive and its consequences in important areas of medicine. Participation in them enables healthcare professionals to evaluate their clinical practice against national standards and guidelines, so that they can continuously improve the quality of treatment and care they provide.

National confidential enquiries perform a similar role, but additionally include critical assessment by senior doctors of what actually happened to patients, with a view to driving up standards and enhancing patient safety.

During 2012/13, 41 national clinical audits and five national confidential enquiries covered NHS services provided by the Trust. The Trust took part in 93% of national clinical audits and all the national confidential enquiries for which it was eligible (see table). For an explanation of the acronyms and other terms used here, please refer to the Glossary in Annex 5.

National Clinical Audits in which the Trust was eligible to participate

Subject	Participated	Cases indicated or required	Cases submitted	% Cases submitted	Comment
Around and after birth (perinatal and neonatal)					
Neonatal Intensive and Special Care (NNAP)	Yes	All admissions	605*	100%	Including 34 re-admissions (total number of babies = 571). Audit carried out per calendar year 2012.
Children					
Paediatric Pneumonia (British Thoracic Society)	Yes	Minimum 20	52	100%	An organisational questionnaire was also completed and submitted
Paediatric Asthma (British Thoracic Society)	Yes	Minimum 20	54	100%	An organisational questionnaire was also completed and submitted
Childhood Epilepsy (Royal College of Physicians)	Yes	All eligible	0*	NA	*Data collection period: 1st Jan—31st Oct 2013. Data collection start has been delayed to April 2013.
Diabetes (Royal College of Paediatrics and Child Health)	Yes	All eligible	223	100%	55 inpatients 168 outpatients
College of Emergency Medicine—Paediatric Fever	Yes	50	50	100%	

Subject	Participated	Cases indicated or required	Cases submitted	% Cases submitted	Comment
Inflammatory bowel disease (IBD)—Paediatric	Yes	50	0*		*Data collection started in Jan and is ongoing until the 31st December 2013
Acute Care					
Emergency Use of Oxygen (British Thoracic Society):	Yes	Minimum 20	26	100%	
Adult Community Acquired Pneumonia (British Thoracic Society)	Yes	Minimum 20	0		In progress. Deadline for submission of data is 31 May 2013
Non-invasive ventilation—adults (British Thoracic Society)	Yes	Minimum 20	0		*In progress. Deadline for submission of data is 31 May 2013
Cardiac Arrest (National Cardiac Arrest Audit)	Yes	All eligible*	33	100%	Data relates to the period Apr-Dec 12.
Adult Critical Care (ICNARC: CMPD)	No	n/a	n/a	n/a	Data is not interpreted on an institutionally individualised basis that is of any benefit to the contributing organisations. The financial cost to participate is also prohibitive.
Potential Donor Audit (NHS Blood & Transplant).	Yes	All eligible cases	Potential=2* Actual=1*	100%	*Audit report period: Apr to Sep 2012
Renal Colic (College of Emergency Medicine)	Yes	50	50	100%	
Long Term Conditions					
Diabetes (National Adult Diabetes Audit)	No	n/a	n/a	n/a	It has been difficult to proceed on this and a review of the resources, methodology and benefit s will be undertaken this year
Chronic Pain (National Pain Audit)	Yes	6	6	100%	
Parkinson's disease (National Parkinson's Audit)	Yes	20	20	100%	
Adult Asthma (British Thoracic Society)	Yes	Minimum 20	25	100%	
Bronchiectasis$_G$ (British Thoracic Society)	No	n/a	n/a	n/a	Trust did not participate as insufficient patients to meet the required sample size.
National Review of Asthma Deaths (RCoP)	Yes	All eligible	1	100%	Trusts are notified of eligible cases by the college. 100% compliance confirmed by college
Pulmonary Hypertension	No	n/a	n/a	n/a	Trust did not participate due to the low number of patients seen as there is no dedicated clinic.
National Dementia Audit	Yes	Minimum 20	35	100%	
Inflammatory bowel disease (IBD)—Adult	Yes	50	2*	n/a	*In progress. Data collection started in Jan and is ongoing until the 31st December 2013
Elective (planned) procedures					
Hip, Knee, and Ankle Replacements (National Joint Registry)	Yes	168	170	100%	
Elective Surgery-Hernia (National PROMs Programme)	Yes	121	112	93%	Using validated data only from April—Sep 12 as advised by the National PROMS Programme)
Elective Surgery: Hip Replacement (National PROMs Programme)	Yes	74	35	47%	Using validated data only from April—Sep 12 as advised by the National PROMS Programme)
Elective Surgery: Knee Replacement (National PROMs Programme)	Yes	80	53	66%	Using validated data only from April—Sep 12 as advised by the National PROMS Programme)
Elective Surgery: Varicose Veins (National PROMs Programme)	Yes	35	22	63%	Using validated data only from April—Sep 12 as advised by the National PROMS Programme)

Subject	Participated	Cases indicated or required	Cases submitted	% Cases submitted	Comment
Heart disease and stroke					
Acute Myocardial Infarction & other acute coronary syndrome (MINAP)	Yes	49	49	100%	
Heart Failure Audit	Yes	29	29	100%	
Sentinel Stroke (SSNAP)	Yes	154	154	100%	Clinical cases submitted are total of those submitted to SINAP (until 31st Dec) and then SSNAP (from 1st Jan). Acute organisational audit submitted also
Cardiac Arrhythmia (Cardiac Rhythm Management Audit)	Yes	69	69	100%	Data from Jan 12 to Jan 13
Cancer					
Lung Cancer Audit: (National Lung Cancer Audit)	Yes	80	58	73%	Data taken from the 2012 Annual report as advised by the National Lung Cancer Audit
Bowel Cancer (National Bowel Cancer Audit Programme)	Yes	54	85	100%	Data taken from the 2012 Annual report as advised by National Bowel Cancer Audit Programme
Oesophago-Gastric Cancer (National O-G Cancer Audit)	Yes	31	31	100%	In progress. This data is submitted in realtime so cases indicated and submitted may change. Deadline for submission of data 31st October 2013.
Trauma					
Hip Fracture (National Hip Fracture Database)	Yes	100	119	100%	Continuous data collection however audit requires hospitals to submit a minimum of 100 cases in a year. Figures from April 12 to Jan 13
Severe Trauma (Trauma Audit & Research Network)	Yes	159	79	50%	It is expected that further cases will be submitted for this year and the % compliance is based on this. The number of expected cases is being confirmed
Fractured neck of femur (College of Emergency Medicine)	Yes	50	50	100%	
Blood Transfusion					
National Comparative Audit of Blood Transfusion: • O neg blood use (10/11) • Platelet use (10/11) • Medical use of blood (11/12) • Bedside transfusion (11/12)	Yes	 40 All eligible All eligible 29	 33 9 46 29	 83% 100% 100% 100%	Contains the following audits, which were previously listed separately in the Quality Report): O neg blood use (2010/11); Medical use of blood (2011/12); Platelet use (2010/11)

National Confidential Enquiry participation

Topic	Participated	Cases indicated or required	Cases submitted	% Cases submitted	Comment
MBRRACE-UK (Mothers and Babies: reducing the risk through audits and confidential enquiries across the UK)	Yes	2	2	100%	
NCEPOD: Child Health—Confidential Enquiry (Epilepsy Related Deaths)	Yes	0	0	n/a	Participation dependent on occurrence of relevant episodes. Single Consultants are contacted to report occurrences, while the Trust is required to participate only if relevant cases are identified.
NCEPOD: Cardiac Arrest Procedures	Yes	2	2	100%	

Topic	Participated	Cases indicated or required	Cases submitted	% Cases submitted	Comment
NCEPOD: Bariatric Surgery	Yes	8	7	88%	
NCEPOD: Alcoholic Liver Disease	Yes	n/a	n/a	n/a	No eligible cases were identified by NCEPOD from the data submitted
NCEPOD: Subarachnoid Haemorrhage	Yes	2	1	50%	This is ongoing

National clinical audit review

The reports of eleven national clinical audits were reviewed by the Trust in 2012/13 and we have taken or intend to take the following actions to improve the quality of healthcare provided.

Audit title	Department leading review	Actions agreed
Emergency Oxygen Audit	Respiratory Department	No issues of concern identified. One area of improvement related to the management of oxygen administration and ensuring that this is reflected on a patient's observation chart. The implementation of the new National Early Warning Score (NEWS) with the accompanying observation chart will address this issue.
National Care of the Dying Audit	Palliative Care	In general Trust performance could be improved and as a result the Trust will be focusing on some key areas to improve standards—these include working towards establishing a 7 day a week, 9-5 face to face Specialist palliative care service for 2014/2015 and incorporating the Liverpool Care Pathway (LCP) documentation into our electronic patient records system to improve completion. A multi-disciplinary care group has been set up which will oversee the ongoing monitoring and implementation of this work. The Trust has chosen End of Life Care as one of its quality priorities for 2013/14.
National Audit of Dementia Care in General Hospitals 2011	Elderly Medicine	The results showed a national picture of a low level of performance, although there was wide variation between participating hospitals on the key dementia-related standards. Some of the actions agreed by the Trust include the identification of 'Dementia Champions' at department and ward level, the development and implementation of a dementia care pathway in order to guide clinicians about how and when to screen for dementia and the refurbishment of many adult wards to ensure that simple and effective improvements to the environment are promoted.
Fracture Neck of Femur	Emergency Department	This report which measures Trusts against standards relating to time to analgesia, X-ray and admission for patients attending A&E with a fractured neck of femur. In general results were good, however, to further improve the time to analgesia and X-ray, the department will reinforce to staff the role of the Rapid Assessment Team$_G$ in expediting this.
Renal Colic	Emergency Department	This report which measures Trusts against standards relating to time to analgesia, time to, and documentation of, investigations and effective organisation of follow up appointments in outpatients or with a patient's GP. In general results were good, however, to further improve the quality of discharge summaries, specific discharge documentation is now being taught as part of induction for new doctors. The audit demonstrated that our A&E is one of the few to operate a fast track policy for patients with renal colic.
National Parkinson's Audit	Neurology	The Trust is generally performing well. A Neurology clinical nurse specialist was appointed in Feb 2013 to aid the provision of patient education and information and involvement of the multi-disciplinary team in a patient's care.
National Neonatal Audit	Neonatal Team	In the latest National Neonatal Audit Programme (NNAP) published report in July 2012 (based on 2011 data from neonatal units in England), the Chelsea and Westminster Hospital Neonatal Unit was recognised as performing particularly well, being one of twenty units that were positive outliers in areas of *Retinopathy of Prematurity (ROP) screening* and *Receipt of own mother's milk on discharge home*. Quarterly reports on the NNAP audit are reviewed by the Neonatal Team and presented to medical and nursing staff.
Paediatric Asthma National Audit	Paediatrics	The results show that care provided at Chelsea and Westminster is on par or better than the national average on all scores. The Trust has scored better at using inhalers rather than nebulisers, compared to national figures. The Trust also performs significantly better than the national average (and our own previous) at avoiding both X-rays and antibiotics. Areas for improvement are the provision of leaflets (22% at Chelsea and Westminster versus 41% nationally) and written plans for discharge (66% at Chelsea and Westminster versus 46% nationally). Although we are doing better in terms of written discharge plans compared to the national average, the Trust is aiming for 100%. The report has been considered locally and the paediatric team will continue with the junior doctor and nursing education programme to keep up the positive work. Management of asthma is already part of induction and postgraduate training programme. The Trust is exploring links with the Brompton Hospital with respect input from an asthma nurse, to oversee education, helping with inpatient management and follow up care. It is thought the Trust is may be unusual not having a designated asthma nurse and the presence of one will ensure that we provide an excellent level of care through the patient journey.

Audit title	Department leading review	Actions agreed
Paediatric Pneumonia	Paediatrics	While the overall result of this audit was very positive and the Trust scored better at performing blood cultures[G] in relevant children, and provides more physiotherapy than the national average locally, the recording of antibiotics given orally appeared to be poor on the notes. It was reiterated to all doctors that oral antibiotics need to be recorded in the medical record, with the rationale for prescribing, as well as within the prescription on the Electronic Patient Record (EPR).
Epilepsy 12	Paediatrics	As a results of this audit the following changes have been put in place—the NICE[G] Pathway and protocols from NICE guidelines have been implemented for management of seizures in Paediatric clinic—a new guideline for children presenting to A&E with afebrile[G] seizures has been developed however this will be ratified after implementation of the new clinic and service improvement arrangements, such as the establishment of a secondary level specialty clinic and a specialist nurse have been worked towards and should be implemented by end of summer 2013.
Fever in Children	Paediatrics	The results of this audit was published in Jan 2013. In response to the results relating to the clinical management of children presenting with fever at Chelsea and Westminster, we will be updating our local clinical guideline to reflect the most up-to-date advice from the College of Emergency Medicine. These changes include revising guidance relating to antibiotic administration and also diagnostic blood testing.

Local clinical audit review

The reports of 131* local clinical audits were reviewed by the Trust in 2012/13 and we intend to take action to improve the quality of healthcare provided. Further details are available on request from Dr Zoë Penn (Medical Director) by emailing zoe.penn@chelwest.nhs.uk.

*In last year's Quality Report the total included ongoing audits. This year's figure includes completed audits only. Last year's figure for completed audits was 139. This year's figure for completed and ongoing is 282.

Goals agreed with commissioners (CQUINs)

A proportion of Chelsea and Westminster Hospital NHS Foundation Trust's income in 2012/13 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Further details of the agreed goals for 2012/13 and for the following 12-month period are available from the Director of Nursing and Quality by emailing quality@chelwest.nhs.uk.

CQUIN in a nutshell
The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of the Trust's income to the achievement of local quality improvement goals.

In 2012/13, income equal to 2.5% of the value of our main contract, which covers most of our NHS services, was conditional on achieving CQUIN goals agreed with our main commissioner, the North West London Commissioning Partnership[G]. Some of these schemes were nationally mandated, whilst the rest were developed locally. The schemes covered the following areas:

National

- Reducing illness and de0ath from venous thromboembolism
- Improving patient experience
- Improving dementia awareness and care
- Improving collection of data for the NHS Safety Thermometer

Local

- Improving information given to GPs
- Using an approved list of medicines
- Improving end of life care
- Increasing number of patients seen by a consultant within 12 hours of admission
- Increasing levels of BCG$_{G}$ vaccinations in newborns

In addition, we also agreed bespoke CQUIN schemes linked to our work in Burns Care, HIV Services and Neonatal Intensive Care. These specialist services were commissioned by the London Specialised Commissioning Group$_{G}$.

We achieved 99% of our Regional and National CQUIN-related goals in 2012/13 for which we received a payment of £4,909k out of a maximum of £4,936k and we achieved 96% of our Specialist Commissioning CQUIN-related goals in 2012/13 for which we received a payment of £1,128* out of a maximum of £1,169k. Overall, we achieved 99% of our CQUIN-related goals in 2012/13 for which we received a payment of £6,037k* out of a maximum of £6,106k.

*The Specialist Commissioning CQUINs are subject to Q4 sign off which will be confirmed in June 2013.

Statement regarding the Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator for health and adult social care services in England. All NHS Trusts are required to register with the CQC$_{G}$ in order to be able to provide their services.

The CQC monitors the quality of services the NHS provides and takes action where these fall short of 'essential' standards. The CQC uses a wide range of regularly updated sources of external information as well as its own observations during spot checks to assess the quality of care a Trust provides. If it has cause for concern, it may undertake special reviews/investigations and impose certain conditions.

Chelsea and Westminster Hospital NHS Foundation Trust is required to register with the CQC and its current registration status is registration without conditions. No enforcement action was taken against the Trust during 2012/2013. The Trust has not participated in any special CQC reviews or investigations by the Care Quality Commission during the reporting period.

More information on the CQC and its regulatory powers is available at www.cqc.org.uk.

Information on the quality of data

Coding

Every hospital in England has to send details of all the care it provides to the Secondary Uses System (SUS)$_{G}$. This anonymised database is used, among other things, to inform national policy and provide a rich source of material for research. The completeness of the coding determines the validity of the information and the Trust's income.

The proportion of records in the published data which included the patient's valid NHS number was:

- 94.8% for admitted patient care (inpatients)*
- 89.6% for outpatient care*
- 85.3% for Accident and Emergency (A&E) care*

*The NHS Information centre does not apply all agreed contractual exclusions for patients with a sensitive diagnosis or no fixed abode. When applying these exclusions the Trust performance improves by 4–8%.

The percentage of records which included the patient's valid General Medical Practice Code was:

- 99.4% for admitted patient care (inpatients)
- 99.7% for outpatient care
- 99.4% for Accident and Emergency (A&E) care

Information Governance Assessment Report

Information governance concerns the way in which organisations process information about patients and staff, and apply the necessary safeguards to ensure that its use is appropriate and secure.

The Information Governance Toolkit is an online system that enables NHS organisations and their partnering bodies to measure how well they are complying with Department of Health standards on the correct and secure handling of data, and how well they are protecting data from unauthorised access, loss, and damage.

The Trust's Information Governance Assessment Report overall score for 2012/2013 was 95% and was graded green (the highest possible grade).

Improving data quality

Clinicians and managers rely on accurate and complete data to enable them to deliver high quality and cost effective care, so we continually strive to improve the reliability of this information as part of quality improvement.

Accurately recorded clinical activity helps us:

- Compare our standards of care with those of other hospitals
- Reduce delays
- Track value for money
- Cut wastage

Monthly checks ensure that reported activity levels are accurate, and we regularly review the way in which all this activity is coded. Managers and frontline staff review and correct data reports every day to make sure they accurately reflect both the care that has been provided and what is about to be provided.

Last year we outlined the ways in which we were planning to improve our data quality and this is what we did:

- The role of the Trust's Data Quality Group was reviewed to ensure that it focused on highlighting areas for improvement and ensuring that the right information was available to the right people/committees at the right time.

- We wanted to make sure that data quality issues were highlighted in performance reports so that managers can brief their teams on any deficiencies in their area— managers are held to account for data quality at monthly divisional board and finance/performance meetings. This was partly achieved: the briefing was verbal and we want to work on making this more formal next year.

- We put in place an updated 'referral to treatment'$_{G}$ module in our main patient administration system which has significantly improved management of patient pathways$_{G}$ and avoided unnecessary delays.

- We continued work on our local performance indicators to ensure that data was correct and meaningful.

- And we developed a formal data quality improvement plan which is monitored by the Trust's Data Quality Group: all data quality issues have been logged, risk assessed, and assigned to individuals to ensure that the resources needed to put them right are allocated appropriately.

Chelsea and Westminster Hospital NHS Foundation Trust will be taking the following actions to improve data quality:

- Increase the focus on data quality issues at the departmental level by reviewing department performance and assigning designated tasks to frontline staff responsible for data entry. Data quality reports will be improved to make them more usable and focused on particular areas of concern. Further training will be provided to frontline staff to address areas of concern highlighted.

- Incorporate key figures on data quality into the Trust executive and divisional performance reports and explicitly discuss these in performance review meetings.

- Implement recommendations from our last data quality audit to improve our understanding of our clinical data on patient deaths and access to our services to inform strategies for improvement.

- Use best practice to remove any inconsistencies in reporting on performance and ensure that information comes from one primary database. This will also include continual checks on data input into our reporting programmes to ensure the data are of good quality.

- Implement the final phase of the 'referral to treatment' module in the patient administration system. This will give us the best means of cutting waiting times and reducing unnecessary delays.

Clinical coding[G] error rate

Diagnoses and treatment need to be coded properly to reflect what actually happens to patients, so it's important to get it right.

Chelsea and Westminster Hospital NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission. The error rate reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) is not yet available.

The results should not be extrapolated further than the actual sample audited. The sample was 80 Finished Consultant Episodes (FCEs)[G]—40 FCEs from HRG[G] Digestive System Procedures and Disorders and 40 FCEs from HRG Paediatric Medicine.

Tell us what you think

We welcome any comments you may have on this report as well as your suggestions for inclusion in future reports. Please contact our Director of Nursing and Quality by emailing quality@chelwest.nhs.uk or calling 020 3315 6599.

Annex 1

Statement of Directors' responsibilities in respect of the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Reports for each financial year.

Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

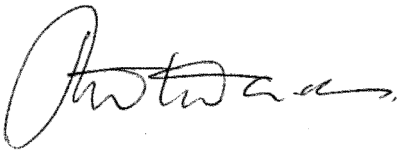
In preparing the Quality Report, directors are required to take steps to satisfy themselves that the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2012/13:

- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2012—April 2013
    - Papers relating to quality reported to the Board over the period April 2012—April 2013
    - Feedback from the commissioners dated 28 May 2013
    - Feedback from governors dated 23 May 2013
    - Feedback from the local Healthwatch organisation dated 20 May 2013
    - The Trust's complaints report 2011/12 published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, September 2012
    - The national inpatients survey 2012
    - The national staff survey 2012
    - The Head of Internal Audit's annual opinion over the Trust's control environment—20 Mar 2013
    - CQC quality and risk profile—February 2013
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) published at www.monitor-nhsft.gov.uk/annualreportingmanual as well as the standards to support data quality for the preparation of the Quality Report published at www.monitor-nhsft.gov.uk/annualreportingmanual.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board.



Professor Sir Christopher Edwards
Chairman
28 May 2013

Tony Bell OBE
Chief Executive
28 May 2013

Annex 2

Auditor's Limited Assurance Report

Independent Auditor's Report to the Council of Governors of Chelsea and Westminster Hospital NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Chelsea and Westminster Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Chelsea and Westminster Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2013 (the "Quality Report") and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of Chelsea and Westminster Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting Chelsea and Westminster Hospital NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2013, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Chelsea and Westminster Hospital NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- *Clostridium Difficile*;
- Maximum 62 day waiting time from urgent GP referral to treatment for all cancers.

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

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

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

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

- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports.*

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

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the documents specified within the detailed guidance. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). Our responsibilities do not extend to any other information.

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

Assurance work performed

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

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.

- Making enquiries of management.

- Testing key management controls.

- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.

- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report.

- Reading the documents.

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

Limitations

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

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

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Chelsea and Westminster Hospital NHS Foundation Trust.

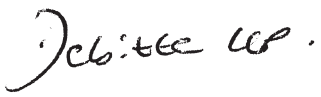
Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

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

- the Quality Report is not consistent in all material respects with the sources specified in the guidance; and

- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual.*



Deloitte LLP
Chartered Accountants
St Albans
29 May 2013

Annex 3

Statements from key stakeholders

Council of Governors response to Chelsea and Westminster Hospital NHS Foundation Trust Quality Report 2012/13

The Council of Governors Quality Sub-committee has continued its work as described in the Governors Commentary on last year's Quality Report. It has contributed its views on many aspects of the quality of the services provided by the Hospital and has endorsed the continued effort to improve the appearance and readability of the Account. The Governors encourage all Trust Members and others who are interested in the Hospital and its performance to read the Account.

Taken as a whole the key performance indicators show a successful year, with some areas which were below par improving. There is still some way to go with some of them, but measures are in place to secure further improvement. It is a tribute to the management of the Trust and the staff in general that this overall high performance has been coupled with a very satisfactory financial performance. This linkage is essential if the Trust is to continue to serve its patients and the public successfully. The Governors encourage the Trust in its forward strategic planning, taking full account of the opportunities which will arise through the reconfiguration of services following the Health and Social Care Act 2012. The Council of Governors is engaging with the Trust Board in this work, which will continue over the next three to five years.

The Governors are pleased that during the year work has continued within the Trust to embed its values (to be kind, excellent, safe and respectful) in everything that is done. Major adaptation of staff training has been completed and this will produce continuing benefits. The Governors have encouraged steps to improve patient and staff feedback and take action on what it has to say about services and the way they are delivered. As part of this individual Governors are joining with non-Executive Directors and Trust staff in ward rounds to talk to patients and front-line staff about these issues.

Last year's Commentary drew attention to the part Staff Appraisals should play in promoting Trust values and improving performance and delivery of services. It continues to be disappointing that the target set for the appraisal rate was again not achieved (in 2011/12 80% against a target of 84% and in 2012/13 82% achieved against a target of 87%). The target set for 2013/14 is 90%. We consider that there should be a 100% appraisal rate, and the Governors will be encouraging further efforts by the Trust's management to that end.

Another issue which has been noted is poor take-up of mandatory training in some areas. On the face of it this is unacceptable though there is a suggestion that this may be due to some mandatory training being specified for staff groups for whom it would not be appropriate. This is to be examined closely and may affect the rate achieved this year. If it is confirmed that certain training should be mandatory for certain groups then the Governors support the Trust Board in their efforts to ensure that it does take place.

Healthwatch Central West London statement to Chelsea and Westminster Hospital NHS Foundation Trust Quality Report 2012/13

Healthwatch Central West London (Healthwatch CWL) welcomes the opportunity to comment on the Chelsea and Westminster Hospital NHS Foundation Trust (the Trust) Quality Report (QA) 2012/13. Under the provisions of the Health and Social Care Act, Healthwatch CWL replaced the Local Involvement Networks on 1 April 2013. The work of the LINks has therefore informed the majority of this submission.

Firstly, we would like to thank Chelsea and Westminster for continuing to engage with us proactively over the last financial year, our members have been involved in much of the patient experience work, included within the Governor sub-committees and have worked closely with senior staff to develop new ideas around engagement mechanisms. Members also continued to be involved in the PEAT assessments (2012) and the nutritional tasting sessions. We were pleased with the overall quality of care provided.

Healthwatch CWL finds the Quality Report 2012/13 has complex formatting which may make it inaccessible for the lay reader. The information on a particular sub-area is scattered throughout the document whereas the reader would benefit from being able to read a whole section on one particular area to include (for example); past performance, NICE benchmark, future targets and how the trust intends on measuring/monitoring future compliance.

However, members would like to commend the Foundation Trust on their award for 'Best Obstetrics VTE Prevention Programme'. However, members are also concerned that the Trust's compliance rate in administering compression stockings is a disappointing 79%. As we have raised this concern in previous years, it would be beneficial to include information on how the rate of compliance is measured and on how the Trust plans to improve over the next year.

Discharge planning does not seem to evidence how medications are administered at that time; there is no mention of this aspect which we understand is a major cause of delays at discharge.

Our members commend the work of the Trust on communicating with its patients and we would like further information on how results of the patient survey will be fed back to patients and to Healthwatch Central West London.

Members would also like further information about how the Trust works with community partners on the 'Trips, slips and falls' prevention programme.

In line with our recent maternity report, we would like to commend the trust on their 'breastfeeding peer support' volunteers. However we are unclear how this initiative will help new mothers discharged after a brief stay in hospital care.

Healthwatch CWL would like to commend the Trust on their work on FGM and are pleased that the Trust is leading the way by ensuring women are given a safe and accessible environment.

Healthwatch CWL would welcome further clarity on:

- **'Clinical Effectiveness: Pressure ulcers'**—we would like further information about how the trust plans to measure the work and what targets will be in place to monitor 2013/14 performance

- **'Good nutrition'**—we would like further information on what mechanisms are in place to assess the need for re-screening and the monitoring of this information

In light of the recent Francis report, Healthwatch CWL would welcome quarterly monitoring data on compliments and complaints. We are keen to ensure local complaints mechanisms are accessible for all. We also want to ensure staff training incorporates the key learning.

Healthwatch CWL looks forward to continuing our strong working relationship with Chelsea and Westminster Hospital NHS Foundation Trust in 2013/14. Our members and volunteers are particularly pleased to be engaging with the Trust on PLACE assessments and with the Council of Governors on the development of Healthwatch.

Contact: Mel Christodoulou, 020 8968 7049/melanie.christodoulou@hestia.org

Local boroughs response to Chelsea and Westminster Hospital NHS Foundation Trust Quality Report 2012/13

Introduction

We welcome the opportunity to comment on the Chelsea and Westminster Hospital NHS Foundation Trust's Quality Account 2012/13. Our respective Councils each have a good working relationship with the Chelsea and Westminster Hospital NHS Foundation Trust.

The Chelsea and Westminster Hospital NHS Foundation Trust has a modern hospital building which achieves excellent clinical outcomes on the Fulham Road. We are pleased Tony Bell OBE was appointed as the new Chief Executive this year.

Chelsea and Westminster Hospital is the lead centre for specialist paediatric and neonatal surgery in North West London which means that they carry out the most complex surgery on babies and children. Last year we were pleased to see the investment in paediatrics on the 1st Floor of the hospital and that the first phase of the child burns unit has been completed.[1] Chelsea Children's Hospital is expected to be completed by the end of 2013.

Performance

We recognise the improvements that have taken place in many areas however issues in some areas still need to be addressed.

1 HSJ (8 Feb 13): The first phase of the Chelsea and Westminster Hospital NHS Foundation Trust's new child burns unit has been completed, its builders have announced.
http://www.hsj.co.uk/hsj-local/acute-trusts/chelsea-and-westminster-hospital-nhs-foundation-trust/first-phase-of-chelsea-and-westminster-hospitals-child-burns-unit-completed/5054206.article?blocktitle=Chelsea-and-Westminster-Hospital-NHS-Foundation-Trust&contentID=4719

We are disappointed to note:

- MHP Health Mandate has published an overall assessment of NHS hospital quality in England, based on 'what matters most to people'. We expected Chelsea and Westminster Hospital NHS Foundation Trust to score higher than 89th out of 146 Trusts.[2]

- The continuing incidences of venous thromboembolism VTE. We agree this should remain a priority area.

- There were three 'never events' this year.

- The Trust did not meet its target for central line continuing care: 94% compliance with care bundles (target 100%).

- The Trust did not meet its target for peripheral line continuing care: 80% compliance with care bundles (target 90%).

- The number of pressure ulcers is a concern. In 2012/13 there were 70 grade 2 (target 50) and 38 grades 3 and 4 (target 31).

- Standard 20 'Consultant-led communication and information to be provided to patients and to include the provision of patient information leaflets' from the London Health Programme 'Quality and safety programme—Audit of acute hospitals' was not met.[3]

- Patients have told the Trust there is room for improvement in communication and the discharge process. We agree 'communication and discharge' should remain a priority area.

- Staff appraisals were a priority for quality improvement in 2012/13. However, the appraisal rate of staff was 82% (target 87%). The Trust also didn't achieve its objective for being in 'the top 20% of acute trusts nationally for staff engagement and staff appraisals as measured by the NHS staff survey'. We note the 3rd priority for quality improvement (patient experience) remains the same in 2013/14.

- 20% of complaints are about the attitude and behaviour of staff. This is the second highest types of complaint.

We note:

- In the CQC survey: Accident and emergency 2012[4] Chelsea and Westminster Hospital NHS Foundation Trust[5] scored on 'overall view of experience' 'about the same' (compared with other trusts).

- The Trust saw an increase in non-elective episodes for the year-to-date 6% higher than last year, a report to NHS London's board revealed.[6]

2 MHP Health (13 Mar 13): Revealed the best NHS hospitals according to the public's priorities http://www.mhpc.com/health/revealed-the-best-nhs-hospitals-according-to-the-publics-priorities/
3 NHS London Health Programmes: Quality and safety programme - Audit of acute hospitals (Chelsea and Westminster Hospital Report) - Audit visit September 12
http://www.londonhp.nhs.uk/wp-content/uploads/2013/02/Chelsea-Westminster-Hospital-Quality-Safety-Audit-Report-FINAL.pdf
4 CQC (6 Dec 12): Accident and emergency 2012
http://www.cqc.org.uk/public/reports-surveys-and-reviews/surveys/accident-and-emergency-2012
5 CQC: People's experiences of Chelsea and Westminster accident and emergency services
http://www.cqc.org.uk/survey/accidentemergency/RQM

- In 2012/13, the Trust conducted many clinical audits. However, we would like to know if any recommendations from the completed audits have failed to be enacted without good reason.

- On 3 May, the Trust had not yet responded in full to the recommendations in the LINk's Maternity Project Report.[7]

We are pleased to note:

- The Trust is a high performing organisation. Nationally, the Trust consistently ranks as one of the best providers of high quality clinical care.

- From Dr Foster, the overall 3 year mortality Hospital Standardised Mortality Ratio compares the actual number of deaths in a trust against the expected number over the last three years. Chelsea and Westminster Hospital NHS Foundation Trust Local performs well (84.13) compared to the national average (100). Separately, the Health and Social Care Information Centre have confirmed, Chelsea and Westminster Hospital NHS Foundation Trust as having 'lower than expected' mortality ratio over a two year period.[8]

- Chelsea and Westminster Hospital NHS Foundation Trust was named as one of the CHKS 40Top Hospitals 2013[9]

- The Trust met all standards assessed in the CQC's unannounced inspection of three wards in July 2012

- The long list of actions the Trust has carried out to improve overall quality: Safety, Clinical Effectiveness and Patient Experience in 2012/13

- Detail on the Trust's quality campaign (pages 41 and 70)

- Excellence for PEAT scores

- The Trust Board is meeting in public again with the agenda and papers available on the internet

Four priority improvement areas

In the first section of the Quality Account document there is a description of what has happened against last year's priority improvement areas.

6 HSJ (8 Feb 13): Chelsea and Westminster Hospital sees spike in non-elective episodes
http://www.hsj.co.uk/chelsea-and-westminster-hospital-sees-spike-in-non-elective-episodes/5054347.article
7 K&C LINk (3 May 13): Maternity Project Report
http://www.rbkclink.org/files/2013/05/Maternity-project-report-final.pdf
8 HSCIC (24 Jan 13): Hospital mortality: report shows trusts with persistently high or low ratios over two year period
http://www.ic.nhs.uk/article/2503
9 CHKS (1 May 13): CHKS announces winners of its Top Hospitals programme awards 2013
http://www.chks.co.uk/userfiles/files/TH13%20overall%20winners.pdf

Priorities for quality improvement 2012/13

1. (Patient Safety): To have no hospital associated preventable venous thromboembolism (VTE)
2. (Patient Experience): Focus on three key areas: communication, discharge planning, and care of older people
3. (Patient Experience): To be in the top 20% of acute trusts nationally for staff engagement and staff appraisals as measured by the NHS staff survey and to ensure our agreed Trust values inform everything that we do.
4. (Clinical Effectiveness): At least 75% of emergency general medical and surgical patients to be seen by a consultant within 12 hours of the decision to admit to hospital or within 14 hours of their arrival at the hospital

Section Two of the Quality Account document describes what will happen against the improvement areas for 2013/14.

Priorities for quality improvement 2013/14

1. (Patient Safety): To have no hospital associated preventable venous thromboembolism (VTE)
2. (Patient Experience): Continue to focus on communication, discharge, and delivering safe and compassionate care to all our patients
3. (Patient Experience): To be in the top 20% of acute trusts nationally for staff engagement and staff appraisals as measured by the NHS staff survey and to ensure our agreed Trust values inform everything that we do
4. (Clinical Effectiveness): To improve choice and quality in End of Life care

Longer-term plans

Finance

The £343m-turnover Chelsea and Westminster Hospital NHS Foundation Trust is considered one of London's most efficient trusts.

The financial outlook for NHS provider trusts in London is considered to be a matter of concern. The Trust is anticipating smaller surpluses in 2013/14 and 2014/15.[10] The trust's annual plan review predicts the percentage surplus will fall from 3.7% this year to 2.3% in the subsequent two. The annual plan review said: 'The trust performed well against its financial plan in 2011/12 and the trust is continuing to plan for levels of EBITDA[11] and surplus well above the Foundation Trust average through the planning period, as it continues to invest in its capital programme to enhance facilities and equipment in order to improve clinical outcomes and efficiency and ensuring we continue to have a sustainable cost base which can adapt to changes in commissioning in the future no matter what they may be.'

The Trust has indicated that it would expand private work[12] (eg bariatrics, plastics and paediatric surgery) if the private patient cap is lifted. We trust that any concentration on promoting the most profitable services do not have any negative impact on the NHS clinical services the hospital provides.

10 HSJ (10 August, 2012): Chelsea and Westminster FT anticipate smaller surpluses http://www.hsj.co.uk/hsj-local/acute-trusts/chelsea-and-westminster-hospital-nhs-foundation-trust/chelsea-and-westminster-ft-anticipate-smaller-surpluses/5048092.article

11 Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA)

12 HSJ (1 Sept 11): FT plans 20% growth in private patient income http://m.hsj.co.uk/5034288.article

The cash pressure could lead to cuts to patient care. The Trust is to be supported in its efforts to make efficiency savings without loss of service.

Shaping a healthier future
We are glad Chelsea and Westminster Hospital NHS Foundation Trust responded so positively to the *Shaping a healthier future* programme. For example, Professor Sir Christopher Edwards, Chairman, has pointed out that the hospital has 'clear plans for the development of A&E.'

Shaping a healthier future
The programme presented its final proposals for service change as a 'Decision Making Business Case'[13] at the Joint Committee of PCTs on 19 February.[14] Thirteen recommendations were agreed[15] including:

- To agree and adopt the model of acute care based on 5 major hospitals delivering the London hospital standards and the range of services should be implemented in NW London.
- To agree that the five major hospitals should be: Northwick Park Hospital, Hillingdon Hospital, West Middlesex Hospital, Chelsea and Westminster Hospital and St Mary's Hospital.

If the Chelsea and Westminster Hospital becomes a Major Hospital there will be increased activity around the Fulham Road. This will need to be carefully managed. The hospital should have updated travel plans, developed in liaison with Transport for London and the Royal Borough of Kensington and Chelsea. This should include provision of clear travel information and car parking.

West Middlesex
We would like to know more about the Trust's long-term plans with West Middlesex.

In September, West Middlesex University Hospital announced it was unviable and would look for merger partners. [16] Chelsea and Westminster Hospital NHS Foundation Trust has bid to take over the £149m-turnover trust and ids now the preferred provider. A Strategic Outline Case will be developed for recommendation to the NHS TDA to proceed to Outline Business Case.[17]

A merger between West Middlesex and Chelsea and Westminster would create an organisation with a turnover well above £400m a year. We would like a reassurance that the combined annual income will be enough to survive the cost pressures and reductions in funding coming over in the next few years.

The outcome of the *Shaping a healthier future* programme means that West Middlesex University Hospital is to become a Major Hospital.[18] This means a full accident and emergency service will be retained on its private finance initiative-funded site.

13 The Decision Making Business Case is set out at:
http://www.northwestlondon.nhs.uk/publications/?category=5870-Decision+Making+Business+Case+-d
14 NHS Alerts (19 Feb 13): Major decision made on the future of healthcare in North West London
http://www.mynhsalerts.london.nhs.uk/2013/02/major-decision-made-on-the-future-of-healthcare-in-north-west-london/?source=email&uid=98&pid=10240
15 Reported on WL CCG website as Major Decision Made (19 Feb 13)
http://www.westlondonccg.nhs.uk/news/major-decision-made.aspx
16 HSJ (20 November 12): Bidders for DGH takeover revealed
http://www.hsj.co.uk/acute-care/bidders-for-dgh-takeover-revealed/5052002.article
17 HSJ (20 November 12): Bidders for DGH takeover revealed
http://www.hsj.co.uk/acute-care/bidders-for-dgh-takeover-revealed/5052002.article
18 NHS Alerts (19 Feb 13): West Middlesex University Hospital is to become a Major Hospital
http://www.mynhsalerts.london.nhs.uk/2013/02/west-middlesex-university-hospital-is-to-become-a-major-hospital/?source=email&uid=98&pid=10237

There is a need for clarity around any plan, if it exists, to move more elective orthopaedic work to West Middlesex.

The West Middlesex University Hospital trust owes a significant legacy debt to the Department of Health, following bailouts in 2006, which any merger partner would be likely to want written off. We would be interested to find out how these discussions are progressing.

We do not want the resource intensive takeover (eg taking forward a takeover itself, bringing the different bodies together and resolving the current issues at West Middlesex University Hospital) to becomes a distraction in any way to the core work at the Trust.

Public health

Public health is now a statutory local authority function but all partners need to take on their responsibility. We encourage the Trust to be fully involved in major public health campaigns and local health promoting strategies.

OSC/Healthwatch

We would be pleased if our scrutiny committee were invited to future stakeholder Quality Account events.

The Trust will have to develop a constructive working relationship with the new Healthwatch organisation.

Conclusion

Overall, the progress that the Trust has made over the last year is to be welcomed, and we look forward to being informed of how the priorities outlined in the Quality Account are implemented over the course of 2013/14.

Councillor Mary Weale
Chairman, Health, Environmental Health and Adult Social Care Scrutiny Committee, Royal Borough of Kensington and Chelsea

Councillor Sarah Richardson
Chairman, Adult Services and Health Policy Scrutiny Committee, Westminster City Council

Commissioners statement in response to Chelsea and Westminster Hospital NHS Foundation Trust Quality Report 2012/13

West London Clinical Commissioning Group (CCG) Quality and Patient Safety Committee has reviewed the Chelsea and Westminster Hospital NHS Foundation Trust's Quality Report (QR) for the year 2012/13. The Trust presented its draft QR for formal comments and has sought the views of the CCG in its development, feedback having been incorporated into earlier drafts. These draft QRs have been reviewed by the North West London Commissioning Support Unit (CSU) encompassing, quality, contracting and performance teams. A draft of the QR was discussed at the West London CCG Quality and Patient Safety Committee on the 22nd of May 2013. Feedback from that meeting was incorporated into the final quality report.

In our view, the QR complies with guidance as set out by both Monitor and the Department of Health (DoH).

Review of Quality Priorities for 2012/ 2013

As clinical commissioners we note that the Trust has made good progress in establishing systems to ensure:

1. **Patient Safety—to have no hospital associated preventable venous thromboembolisms (VTE).** We acknowledge and support the work the Trust has undertaken to reduce VTE's through audit, preventative treatment, patient information and training and the ongoing goal to ensure that there will be no hospital associated VTEs.

2. **Patient Experience—to focus on three key areas; communication, discharge planning and the care of older people.** Ensuring positive patient experience is kept central to service delivery is core to the services we commission for our population. We support the work that the Trust has undertaken in starting to embed core trust values and behaviours and welcome the transparency in openly sharing feedback on how such values and behaviours are being embedded in practice. We are pleased that this will continue to be a priority for the Trust in 2013/ 2014.

3. **Patient Experience—to be in the top 20% of acute trusts nationally for staff engagement and staff appraisals as measured by the NHS Staff Survey and to ensure agreed trust values inform everything that the trust does.** We recognise the complexity of organisational and ward/ departmental cultures and the work that needs to be undertaken to embed positive core values and behaviours at every level of an organisation. We acknowledge the work that the Trust has undertaken in celebrating staff achievements; appraisals; embedding trust values and ensuring staff engagement to promote and facilitate ownership of such values and behaviours.

4. **Clinical Effectiveness—for at least 75% of emergency general medical and surgical patients to be seen by their consultant within 12 hours of the decision to admit to hospital or within 14 hours of their arrival at the hospital.** Ensuring timely review and management of non elective medical and surgical patients is key to enabling proactive, timely management and treatment leading to better outcomes for patients. We acknowledge the work that the Trust has undertaken to ensure this happens, the achievement of the 75% review criteria set out in this priority and the 90% target now set which will be monitored by commissioners and stakeholders through monthly Clinical Quality Group Meetings.

Priorities for Quality Improvements 2013/ 2014

The Trust has identified four priorities for improvement for 2013/14, these priorities have clearly been identified through review of progress made against the objectives it set last year. Three of the priority areas are the same as last year and the commissioners support this commitment to drive and consolidate improvements in these areas. We recognise that to build on the priorities from last year, the benefits and improved quality of care for patients will be far more sustainable in the long term. We look forward to the Trust achieving its goals and seeing the impact on the quality of care for patients.

1. **Patient Safety—to have no hospital associated preventable venous thromoembolisms (VTE).** The Trust continues to strive towards achieving zero tolerance for hospital associated preventable VTE's and commissioners support this ambition.

2. **Patient Experience—to continue to focus on; communication, discharge and delivering safe and compassionate care to all patients.** The commissioners look forward to seeing further improvements in patient experience performance indicators across the organisation, as well as further information on how NHS England's Compassion In Care Nursing strategy will be rolled out across the Trust.

3. **Patient Experience—to be in the top 20% of acute trusts nationally for staff engagement and staff appraisals.** The commissioners recognise and endorse the evidence that suggests there is a direct link between a motivated, empowered workforce and the quality of care patients receive and look forward to seeing the Trust achieve its target.

4. **Clinical Effectiveness—To improve choice and quality in End of Life care.** The Trust has identified that improvement could be made in this area of care, with a particular focus on dignity, and will create a two year strategy to address this key area. Although the commissioners acknowledge improving the quality is paramount, creating outcome monitoring tools are also key in demonstrating improvements and we look forward to seeing ways in which the trust plans to monitor improved quality as a result of this being identified as a priority.

As commissioners we are committed to ensuring that lessons are learnt when things go wrong in an organisation. We will continue to work with the organisation to gain assurance that a robust systematic process is embedded for grading and reporting all Serious Incidents and Never Events. We will also continue to monitor and review incidents as well as themes, and trends following Serious Incidents and Never Events, ensuring lessons are learnt and shared.

The commissioners would like to commend the fact that the Trust has clearly engaged and consulted with a number of its key stakeholder groups during the planning phase of drafting this QR. We would also like to note that effort was obviously made to include 'the patient's voice' as an integral part of developing the document. This 'inclusive' approach to drafting and developing the QR is welcomed by commissioners.

Concluding Statement

West London CCG will continue to work with the Chelsea and Westminster Hospital NHS Foundation Trust in further developing and monitoring the quality of service it provides for patients. Whilst we recognise improvements made in 2012/13, we hope the Trust finds these comments helpful and we look forward to continuous improvements and productive collaborative working in 2013/14.

Ian Blake
Vice Chair
West London CCG

Daniel Elkeles
Chief Officer
CWHH CCGs Collaborative

Annex 4

Response to statements

The Trust is grateful for the considered responses from all our stakeholders and their input in developing our quality report. These have been helpful and will be considered where appropriate with the relevant stakeholders in 2013/14.

Annex 5

Glossary

Abbreviation	Meaning / Definition
15 Step Challenge	The 15 Steps Challenge, created by the NHS Institute of Innovation and Improvement, focuses on seeing care through a patient's eyes and exploring their first impressions. The Challenge helps staff listen to patients and their carers and to understand what works well and what needs to be improved.
A&E	Accident and Emergency Department
Afebrile	Normal body temperature
Baby Friendly Initiative	The Baby Friendly Initiative is a worldwide programme of the World Health Organization and UNICEF. It was established in 1992 to encourage maternity hospitals to implement the Ten Steps to Successful Breastfeeding and to practise in accordance with the International Code of Marketing of Breast milk Substitutes.
Bariatrics	The field of medicine that focuses on the treatment and control of obesity and diseases associated with obesity.
BCG	An immunisation that has been shown to give 70–80% protection against TB (Tuberculosis). The vaccine is given in a single dose following a 'negative' mantouxG test.
Bed Days	The measurement of a day that a patient occupies a hospital bed as part of their treatment.
Blood culture	A blood culture is a laboratory test to check for bacteria or other microorganisms in a blood sample. Most cultures check for bacteria.
Bronchiectasis	Inflammation and damage of the bronchi in the lungs. Bronchi are the two main branches of the trachea/windpipe that go into the lungs.
BTS	British Thoracic Society.
C.difficile (*Clostridium difficile* or *C.diff*)	A specific kind of bacterial infection that causes mild to very severe forms of diarrhoea and colitis.
CAP	Community Acquired Pneumonia.
Care bundle	A care bundle is the end result of an extensive review of literature which identifies the key elements/aspects/intervention of care. If all interventions are performed, the relevant risk of infection is minimised. If not all interventions are performed the risk of infection increases.
Care bundle—ventilator associated pneumonia	As described above, a care bundle is a way of ensuring that recommended evidence based clinical care for patients is actually delivered. The ventilator care bundle is made up of 4 elements, to nurse the patient at 30º head up to prevent gastro-oesophagealG reflux, to give preventative treatment for stomach ulcers, to give preventative treatment for clots and to stop sedatives for a period of time daily which reduces the length of stay in the Intensive Care Unit.
Care Quality Commission (CQC)	This regulatory organisation checks whether hospitals, care homes and care services are meeting government standards.
CEMACE	Centre for Maternal & Child Enquiries.
Central line	A tube called a catheter placed into a large vein used to administer medication or fluids, obtain blood tests and obtain cardiovascular (pertaining to, or affecting the heart and blood vessels) measurements.
Central line continuing care—% compliance with Care bundles	Compliance of care in percentages for a catheter placed in a large vein regarding the 'Care Bundles'
CEWSS	Chelsea Early Warning Score System.
CLAHRC	Collaboration for Leadership in Applied Health Research and Care.
Clinical Coding	Clinical Coding is the translation of medical terminology as written by the clinician to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format.
Clinical Commissioning Groups	New NHS system supported by and accountable to the new NHS Commissioning Board. These groups have assumed the responsibility for commissioning health services. Local General Practitioner practices are amongst other health professionals in a Clinical Commissioning Group, which will be responsible for "commissioning"—planning, designing and paying for NHS services. This will include planned and emergency hospital care, rehabilitation, most community services and mental health and learning disability services
Colposcopy	An investigative diagnostic procedure in which a gynaecologist uses an instrument to look at the cervix and the entrance to the neck of the womb and sometimes to take a small sample or biopsy.

Abbreviation	Meaning / Definition
Comfort Rounds	'Comfort rounds' generally take place for patients every two hours. They are proactive and conducted by ward staff who visit every patient to ask them if they would like anything to make them more comfortable. The 'round' can provide patients an opportunity to ask for anything they need, without having to attract the attention of a member of staff.
Commissioners	A body that identifies the health needs of the local population. Commissioners also evaluate and purchase health services for patients (such provided in hospitals).
Commissioners (CWHH)	Central London, West London, Hammersmith and Fulham and Hounslow (CWHH) Clinical Commissioning Groups
Commissioners—North West London Commissioning Partnership (NWLCP)	The eight Primary Care Trusts in NW London have formed a sector-wide North West London Commissioning Partnership (NWLCP) which is developing the capacity of the NHS to commission and manage the performance of acute (hospital based) services from the seven main acute providers in NW London.
Commissioners—The London Specialised Commissioning Group	The London Specialised Commissioning Group works on behalf of London's Primary Care Trusts (PCTs) to ensure the people of London have access to the most specialised healthcare when they need it, and to improve the quality and value for money of specialised care. Source: the website of the London Specialised Commissioning Group www.londonspecialisedcommissioning.nhs.uk
Compression stockings	These stockings help maintain circulation in the leg veins and reduce leg swelling. They can help reduce the risk of blood clots forming in the veins of the legs (DVT).
COPD	Chronic Obstructive Pulmonary Disease.
COPD discharge care bundle	This care bundle is a group of evidence based items that should be delivered to all patients being discharged from the hospital following an Acute Exacerbation of Chronic Obstructive Pulmonary Disease.
Corporate Induction Programme	A programme or plan used in the workplace context whereby employees adjust or acclimatise to their jobs and working environment in a new organisation.
CQUIN	Commissioning for Quality and Innovation (a payment framework that enables commissioners to reward excellence by linking a proportion of providers' income to the achievement of local quality improvement goals).
Craniofacial	Pertaining to the portion of the skull that contains the face and brain.
Dementia	A set of symptoms which include loss of memory, mood changes, and problems with communication and reasoning. These symptoms occur when the brain is damaged by certain diseases.
Dementia CQUIN	Four staff members will complete NHS London training and will then ensure further training is provided to Trust staff working in specific areas—25% of all nurses, 40% of allied health professionals (includes therapists), 40% of junior doctors, 65% of consultants and speciality registrars. The CQUIN also includes an incentive to reduce inappropriate prescribing of anti-psychotics.
Dementia Friendly	'Dementia friendly' means providing care that meets the patient's needs throughout the hospital through a range of approaches. This includes a suitable and safe environment for those with dementia, care which is responsive to individual needs of the patient and which is delivered by an expert multi professional team .
DoH/DH	Department of Health
Doulas	A experienced woman who offers emotional and practical support to another woman (or couple) before, during and after childbirth.
Dr Foster	A A hospital guide with a comprehensive directory of NHS and private hospitals
DVT	Deep Vein Thrombosis
EDU	Endoscopy Decontamination Unit—an area where there are dedicated facilities and staff to decontaminate (to eliminate contamination) of flexible endoscopes used during specific patient procedures.
Elective	A planned clinical procedure
End of Life Care Committee	A committee in the hospital that oversees the strategy and management of 'End of Life Care' for patients in the Trust.
Engagement (as defined in the staff survey)	The CQC has provided an overall 'Staff Engagement Score' for the last three years. This includes staff's perceived ability to contribute to improvements at work, their willingness to recommend the Trust as a place to work/receive treatment, and the extent to which staff feel motivated and engaged with their work. The Trust's engagement score was 3.81 (on a Likert scale of 5, where 5 is best) placing us in the top 20% of acute trusts nationally for the third year running.
Equality and Diversity Steering Group	The committee that undertakes the Trust's Equality and Diversity objectives.
Essential Standards for Quality and Safety	Privacy and dignity through the senior nursing and midwifery clinical rounds.
Excellence in Care Programme	A programme of work to drive forward care excellence.

Abbreviation	Meaning / Definition
Executive Quality Committee	The aim of the Executive Quality Committee aims to provide direction and support to the Divisions for quality (safety, effectiveness and patient experience), monitor progress against the quality objectives, and maintain corporate clinical accountability.
Falls per 1,000 Bed Days	The number of patient falls per1000 bed days.
FCE	Finished Consultant Episode—an episode of care from a Consultant to a patient that has concluded.
Foundation Trust	NHS Foundation trusts are not-for-profit, public benefit corporations. They are part of the NHS and provide over half of all NHS hospital, mental health and ambulance services.
Foundation Trust Governors	Governors in Foundation Trusts provide an important link between the hospital and the local health community, enabling the gathering of views from local people and to feedback what is happening within the Trust. They reflect stakeholder interests and work on their behalf to improve health services. Governors do not have any administrative powers in the hospital, but they have Statutory responsibilities, which are set out in the Health and Social Care (Community Health and Standards) Act 2003. Governors are also expected to follow the requirements of the Code of Governance published by Monitor, the Independent Regulator for Foundation Trusts.
FY1 (Foundation Year 1)	'Foundation Year 1' enables medical graduates to begin to take supervised responsibility for patient care and consolidate the skills that they have learned at medical school.
FY2 (Foundation Year 2)	The F2 year furthers the acquisition of knowledge and skills beyond the previous F1 year. It is expected that F2 trainees will support and guide their F1 colleagues in their training needs and work. Besides attending their mandatory educational programme, specialities are explored further.
Gastro-oesophageal reflux	A condition in which the acidic contents from the stomach regurgitate or reflux (wash back) into the oesophagus (the gullet).
General Surgery, Ophthalmology	The branch of surgery that deals with the anatomy, functions, pathology, and treatment of the eye.
Hand hygiene compliance rates/completion rates	Staff compliance with the World Health Organisation '5 moments of hand hygiene'. These are: cleaning hands before and after patient contact, before aseptic tasks, after contact with body fluids and after contact with the patient's environment (within 6ft radius of the patient's bed). Completion rates denote the completion rates of the audits undertaken to monitor hand hygiene.
HRG	A grouping consisting of patient events that have been judged to consume a similar level of resource.
HDU	High Dependency Unit.
Healthwatch Central West London	Healthwatch Central West London is the new independent consumer champion for local health and social care services in Hammersmith and Fulham, Kensington and Chelsea and Westminster.
HIV	Human immunodeficiency virus.
HIV Neurocognitive	An HIV related decline in cognitive function, including trouble with concentration, memory, and attention. Persons also show progressive slowing of motor function and loss of dexterity and coordination.
HSMR	Hospital Standardised Mortality Ratio (An indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than expected).
IBD	Inflammatory bowel disease.
ICNARC CMPD	Intensive care national audit and research centre Case mix programme database
ICU	Intensive Care Unit
Inpatient falls per occupied 1,000 bed days	The number of patient falls per 1,000 inpatient bed days.
IPCC	Infection Prevention and Control Committee.
'Lifeblood'	The Thrombosis Charity that wishes to increase awareness of thrombosis among the public and health professionals and to raise research funds to improve patient care
LINk	Kensington and Chelsea Local Involvement Network.
Liverpool Care Pathway (LCP)	The LCP is an integrated care pathway that is used at the bedside of a dying patient to promote quality of care in the last hours and days of life.
Mantoux test	A Mantoux test is a skin test used to test someone for signs of exposure to Mycobacterium tuberculosis, the bacterium that causes tuberculosis infection.
MBRACCE perinatal mortality	Relevant to mothers and babies: reducing risk through audits and confidential enquiries across the UK. It is the interim arrangement for reporting maternal and perinatal deaths.

Abbreviation	Meaning / Definition
Medicine for Members	Medicine for Members is a free health seminar for the hospital's foundation Trust members. The Medicines at Discharge (M@D) project hosted the first 'Managing Your Medicines' event with Local Involvement Network (LINk) for Kensington and Chelsea in July 2012. A seminar from that event was presented again at a Medicine for Members in February 2013. The seminar was presented by Dr Iñaki Bovill (Consultant in Medicine for the Elderly) and Shirley Kuo (Clinical Pharmacist). The topic proved popular with 33 people attending with many questions from the audience after the presentation. Feedback from those who attended was very positive with 100% of respondents 'agreeing' or 'strongly agreeing' that they found the event useful.
MINAP	Myocardial Ischaemia National Audit Project established in response to the national service framework (NSF) for coronary heart disease, to examine the quality of management of heart attacks in hospitals in England and Wales.
MRSA bacteraemia	The presence of Methicillin-resistant Staphylococcus aureus bacteria in the blood.
Multidisciplinary Group	A group of health care workers who are members of different disciplines, each providing specific services to the patient.
National Reporting and Learning System (NRLS)	The system enables patient safety incident reports to be submitted to a national database. Data is analysed to identify hazards, risks and opportunities to improve the safety of patient care.
NCDAH	National Care of the Dying Audit.
NCEPOD	NCEPOD National Confidential Enquiries into Patient Outcome and Death. An organisation that is published reports derived from a vast array of information about the practical management of patients.
NEST	Nurturing Essential Support for Transition to motherhood.
Never Events	Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
NHS Institute for Innovation and Improvement	This organisation aims to support the NHS transform healthcare for patients and the public through the development and dissemination of innovative approaches and methodologies.
NICE	National Institute for Health and Care Excellence.
NIHR	National Institute of Health Research.
Nil by Mouth	To withhold oral food and fluids from a patient.
NNAP (neonatal and special care)	National Neonatal Audit Programme.
NRLS	National Reporting and Learning System.
NWLCP	North West London Commissioning Partnership (NWLCP) The eight Primary Care Trusts in NW London have formed a sector-wide North West London Commissioning Partnership (NWLCP) which is developing the capacity of the NHS to commission and manage the performance of acute (hospital based) services from the seven main acute providers in NW London.
Occupied per 1,000 bed days	Occupied bed days are derived from the ward listing total beds occupied, which should be recorded each day as part of the daily ward listing. This daily count should then be totalled across the period for which the data is required.
PSEC	Patient and Staff Experience Committee
Patient Safety Incidents per 100 admissions	Comparative reporting rate used nationally to determine each organisation's incident reporting rate.
PE	Pulmonary Embolism—obstruction within the pulmonary arterial tree from a blood clot.
PEAT	Patient Environment Action Team PEAT is an annual self-assessment, established in 2000, of inpatient healthcare sites in England with more than 10 beds. Scores range from 1 (unacceptable) to 5 (excellent) for a range of key areas including: food and food service; cleanliness; access and external areas; infection control; privacy and dignity; and patient environment (including toilets and bathrooms, lighting, floors, patient areas, etc.).
PEAT Scores	Scores from 1 (unacceptable) to 5 (excellent) for standards of environment, food and dignity and privacy within buildings) for PEAT assessments in the NHS.
Percentage of patients nutritionally screened on admission	The percentage of nutritional screening undertaken. Nutritional screening is considered to be the first step to identifying patients who may be at nutritional risk or potentially at risk of malnutrition. In addition this screening process provides opportunity for the patient's ability to eat and drink safely to be assessed.
Peripheral line	A short, thin, plastic tube that goes through the skin and into a vein. This can be connected to and infusion to deliver fluids and medication or a syringe.
Peripheral line continuing care—% compliance with Care bundles	Compliance of care in percentages for a venous catheter placed in a small vein regarding the Care Bundles

Abbreviation	Meaning / Definition
PHSO	Parliamentary Health Services Ombudsman.
PLACE	Patient Led Assessment of the Care Environment.
PP	Patient Pathways
Pressure ulcers	Open wounds that form whenever prolonged pressure is applied to skin covering bony areas of the body. Pressure ulcers are commonly known as bedsores.
Pressure Ulcers - grade 2	Partial-thickness skin loss or damage involving epidermis and/or dermis. The pressure ulcer is superficial and presents clinically as an abrasion, blister or shallow crater.
Pressure ulcers grades 3 & 4	As determined by the European Pressure Ulcer Advisory Panel grading system and adapted for this glossary: Grade 4: Full thickness skin loss involving muscle, bone or supporting structures Grade 3: Full thickness skin loss involving damage to subcutaneous tissue (the deepest layer of skin) that may extend to but not through the underlying fascia (strong connective tissue).
ProMISe trial	Protocolised Management In Sepsis (ProMISe): a multicentre, randomised controlled trial of the clinical and cost-effectiveness of early goal-directed protocolised resuscitation for emerging septic shock.
PROMS (Patient Reported Outcome Measures)	PROMs measure quality from the patient perspective for four procedures, hip replacements, knee replacements hernia and varicose veins. They are short, self-completed questionnaires, which measure the patients' health status or health related quality of life at a single point in time. The indicated cases is a figure based on the previous year's numbers so conclusions have been drawn on how many procedure we will be performing in one year based on how many we performed the year before so is only an estimate. Cases submitted are an average monthly return rate as the data is collected monthly.
Protected characteristic	A new term given to the grounds upon which discrimination is unlawful in the Equality Act 2010. The characteristics are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. These were locally referred to as 'equality strands'.
Puerperal Sepsis	Puerperal sepsis is an infection of the genital tract by organism occurring within 14 and 21 days after childbirth or abortion.
Pulse survey	A pulse survey is typically a type of survey given to employees of an organisation to better gauge and evaluate employee satisfaction, productivity, and overall attitude.
Q1 or Quarter 1	The period Apr–Jun 2011
Q2 or Quarter 2	The period Jul–Sep 2011
Q3 or Quarter 3	The period Oct–Dec 2011
Q4 or Quarter 4	The period Jan–Mar 2012
Rapid Assessment Team	A specialist multidisciplinary team in the Trust that provides an urgent and targeted service for patients with fractured neck of femur with the aim of ensuring good patient care outcomes.
RCA	Root Cause Analysis
RCOG	Royal College of Obstetricians and Gynaecologists
RCP	Royal College of Physicians
RCPCH	Royal College of Paediatrics and Child Health
Referral to Treatment	90% of admitted and 95% of non-admitted patients should start consultant-led treatment within 18 weeks of referral from a general practitioner
Regulators	Regulators oversee the health and social care professions by regulating individual professionals and organisations. Each regulator was set up to protect the public so that health or social care professionals meet certain standards. Regulation is important to standards of treatment and care,
SHMI	Summary Hospital-Level Mortality Indicator—a new indicator for mortality. The indicator is for non-specialist acute trusts, and covers all deaths of patients admitted to hospital and those that occur up to 30 days after discharge from hospital.
SINAP	Stroke Improvement National Audit Programme
Stakeholder	A person, group or organization that has interest or concern in an organization.
SNMC	Senior Nursing and Midwifery Committee
SUS	Secondary Uses Service—Provides anonymous patient-based information for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.
TARN	Trauma Audit & Research Network.
Tertiary	Tertiary Services are specialised health services that are provided in hospitals on a regional basis.

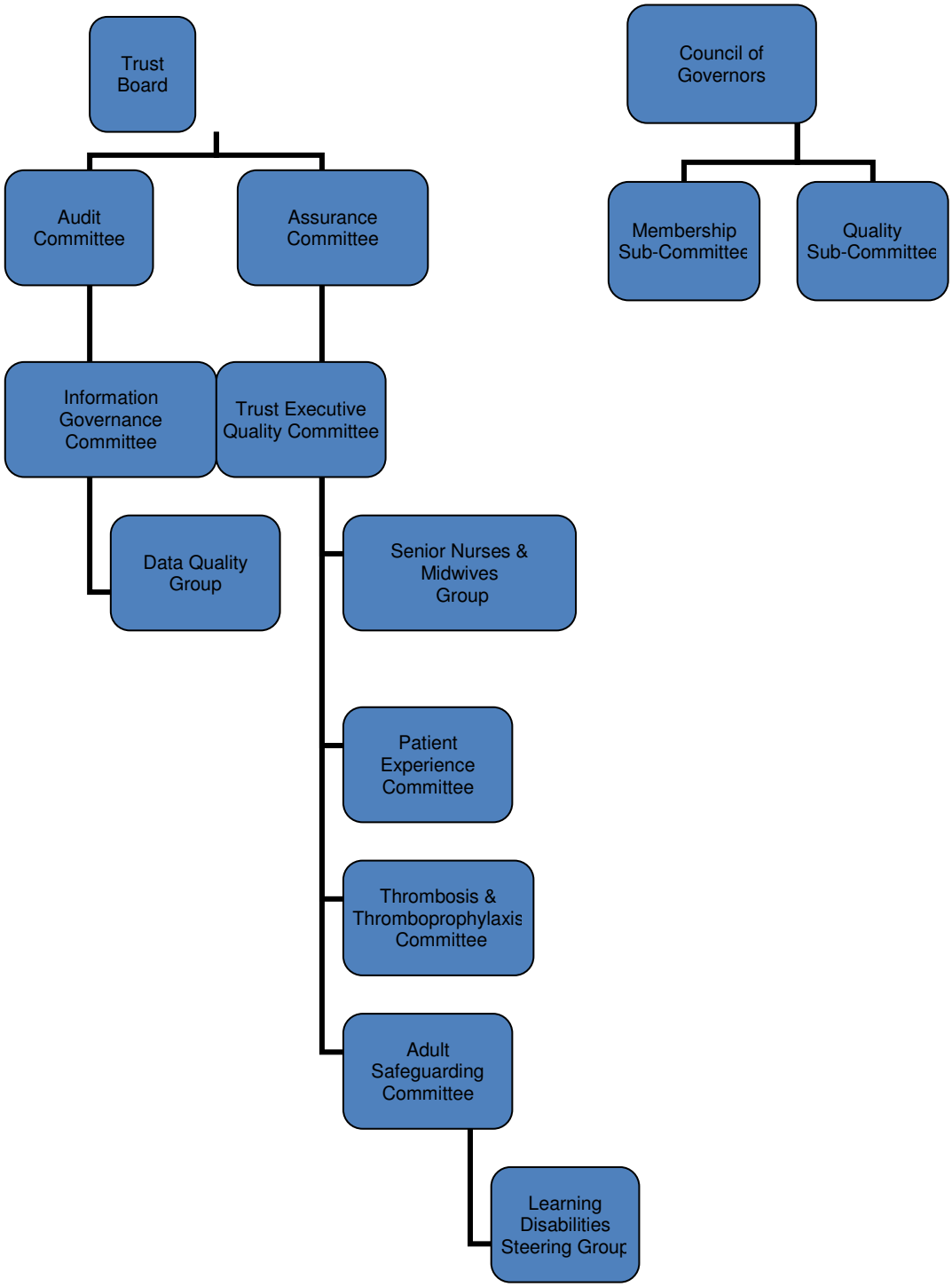
Abbreviation	Meaning / Definition
The London Specialised Commissioning Group	The London Specialised Commissioning Group works on behalf of London's Primary Care Trusts (PCTs) to ensure the people of London have access to the most specialised healthcare when they need it, and to improve the quality and value for money of specialised care.
Thromboprophylaxis	Prevention of venous thrombosis (blood clots) forming in veins within the body.
Thrombosis	Thrombosis is a blood clot within a blood vessel. It happens when a blood clot forms and blocks a vein or an artery, obstructing or stopping the flow of blood.
Thrombosis and Thromboprophylaxis Committee	The committee in the hospital that oversees the work of prevention and treatment of blood clots.
Trans	The word 'trans' is often used as an umbrella term to describe people who feel their gender is, or has been, different from the one they were labelled with at birth in more recent times even before their birth.
Triage	The process of sorting people based on their need for immediate medical treatment as compared to their chance of benefiting from such care.
Trust Executive Quality Committee	The aim of the Executive Quality Committee is to provide direction and support to the Divisions for quality (safety, effectiveness and patient experience), monitor progress against the quality objectives, and maintain corporate clinical accountability.
Trust News	In house publication featuring a letter from the Chief Executive Officer and articles about staff and events in the Trust.
Urinary catheters continuing care—% compliance with Care bundles	Compliance of care in percentages for a urinary catheter placed in the bladder regarding the 'Care Bundles'
VTE	Venous thromboembolism—the collective term for deep vein thrombosis (DVT) and pulmonary embolism (PE).
VTE target 2012/13	The Trust had 10 preventable cases of VTE in 7 months. If this is extrapolated to 12 months this is 17. A 25% reduction is therefore 13.
Wayfinding Project	This is a project which will involve staff, patients and visitors on how to make it easy for everyone to find their way about.
Wellbeing Boards	The Health and Social care Act 2012 established Health and Wellbeing Boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities.
Wellbeing rounds	A regular routine check made by nurses to find out if patients are comfortable, pain free, and if they have any other needs.

Annex 6

Trust Committee structure and Clinical Divisional structure

Trust Committee Structure

(includes committees referred to in the text only)



Clinical Divisional structure

Division of Medicine and Surgery

- Accident and Emergency (A&E)
- Medicine
- Surgery
- Burns
- Pain
- Cancer

Division of Women, Children and Sexual Health

- Maternity
- Paediatrics
- NICU
- Gynaecology
- HIV
- Sexual Health
- Dermatology

Division of Clinical Support

- Pharmacy
- Critical Care
- Therapies
- Diagnostics
- Theatres
- Decontamination Services
- Anaesthetics
- Radiology
- ICU
- Outpatients

OVERVIEW OF FINANCIAL PERFORMANCE

Review of financial performance

The Trust has maintained its strategic approach to delivering a significant Cost Improvement Programme (CIP) to ensure financial stability.

The Trust achieved a CIP of £16.2 million (6% of controllable costs) in 2012/13 following a CIP of £19.7 million (9% of controllable costs) in 2011/12.

In 2012/13 the Trust's financial performance was given a financial risk rating of 5 out of 5 by Monitor, where 5 is 'low risk', and delivered a surplus of £13.0 million which was £0.4 million ahead of plan.

The Trust's annual income and expenditure is set out below.

Summary 2012/13 Income & Expenditure Outturn vs Plan (£m)

		Plan 2012/13	Actual 2012/13	Variance 2012/13
Income				
	Clinical Income	305.9	304.9	(1.0)
	Donation & Grant Income for Capital projects	1.7	1.9	0.2
	Non-Clinical Income	38.2	39.1	0.9
Total income		345.8	345.9	0.1
Expenses				
	Pay costs	178.2	176.9	1.3
	Non-pay costs	132.3	133.4	(1.1)
Total Expenses		310.5	310.3	0.2
Operating Surplus before Depreciation		35.3	35.6	0.3
Depreciation		12.1	11.7	0.4
Dividend on PDC		9.8	9.9	(0.1)
Interest		0.8	0.8	0.0
Loss on disposal of asset		0.0	0.1	(0.1)
Net Surplus		12.6	13.0	0.4
Cost Improvement Programme (CIP)		16.2	17.1	0.9

Key variances from plan in 2012/13

Clinical income was £1.0 million below plan due to reduced levels of activity across several elective specialties offset by a better performance against commissioner metrics than planned.

Donations and Grants Income to fund Capital projects was £0.2 million ahead of plan because we received charitable capital donations for the new paediatric burns unit which opened in December 2012.

Non-clinical income was £0.9 million higher than plan due to increased income through R&D projects.

Pay costs were £1.3 million lower than plan reflecting slightly lower levels of activity and the continued control of temporary staffing in line with this activity.

Non-pay costs were £1.2 million higher than plan due to pricing increases including Energy.

Depreciation and amortisation was £0.4 million lower than plan due to slippage in the delivery of the Trust's capital plan.

The Trust has met the requirement in 2012/13 that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. For the purposes of this comparison, donated, training, and research income has been included within income, with the majority of this income attributable to the provision of the health service in England. Research and training income in relation to non-NHS patients or training has been treated as non-NHS income.

Approximately 94% of total operating income in the year related to the provision of goods and services for the health service in England. The remaining 6% of total operating income relates predominantly to the provision of services to private and overseas patients and other non-patient related services such as car parking, rental of space and provision of utilities. These areas of the Trust's operating activities are complementary to the main healthcare activities of the Trust and generate income to allow for further investment in the Trust's core activity, which is the provision of services to NHS patients.

REVIEW OF NON-FINANCIAL PERFORMANCE

Introduction

As a Foundation Trust our clinical and financial performance is regularly assessed by Monitor. Monitor are responsible for safeguarding choice and preventing anti-competitive behaviour; setting prices for NHS-funded care; enabling integrated care; supporting commissioners to protect essential health care services for patients if a provider gets into financial difficulty; licensing Foundation Trusts and ensuring they are well-led in terms of quality and finances.

Chelsea and Westminster is compliant against all Monitor targets and has fully achieved against the Monitor performance framework for 2012/13. We are delighted to announce that Chelsea and Westminster has the best record in the country for the four hour A&E national target. This is testament to the commitment of the A&E and patient flow teams in diagnosing and treating patients efficiently over the past year.

Indicator	2012/13 target	End of year result 2012/13
Clostridium difficile	31 cases or less	15
MRSA	2 cases or less	1
A&E (4 hours or less)	98%	98.5%
Discharge summaries	80% sent to GPs within 24 hours	80%
Outpatient letters	90% sent to GPs in 5 working days	87%
VTE assessment	90% of patients risk assessed	92.7%

We have made strong in-roads this year to improve our processes and efficiency, which will allow us to provide a speedy service to patients and a better experience. But there is always more that needs to be done and in 2013/14 we will work to reduce our non-attendance rate and improve how quickly patients receive their outpatient letter to confirm their appointment as part of an overall outpatient service review.

2013/14 will also see transformation work in outpatients to increase productivity and improve on patient experience. Various schemes are also planned to improve surgical pathways such as optimising the fractured neck of femur pathway, increasing the productivity of our operating theatres and driving down the number of operation cancellations.

Negotiations continue with NHS England (formerly the National Commissioning Board) regarding specialised services that we provide on behalf of larger community areas such as sexual health and burns.

The Trust, in discussion with commissioners, have agreed to focus attention on reducing levels of avoidable emergency admissions. Achieving a reduction in preventable admissions will release financial savings to the health community, ensure more appropriate care for patients and releasing hospital capacity.

To facilitate the reduction of admissions a joint incentive scheme involving Central London Community Healthcare has been established to manage emergency pathways using community capacity where clinically appropriate.

In addition to Monitor's performance framework we measure ourselves on a monthly basis against six focus areas that, if all achieved, come together to show a good bill of health for the organisation. These areas are patient safety, clinical effectiveness and maternity, patient experience and access, process efficiency, workforce and finance.

We have performed well in each of the six areas and particular achievements to highlight include over 98% of A&E patients being diagnosed and treated within four hours, all cancer targets being consistently exceeded throughout the year, over 92% of mothers choosing to breastfeed, nearly 96% of patients recommending the hospital to friends and family and all appropriate patients being treated in single sex facilities to maintain their privacy and dignity.

We have made great in-roads in the care of patients with dementia, illustrated by our shortlisting for the CHKS award for Excellence in Dementia Care and in developing a dementia friendly hospital environment in line with the King's Fund recommendations for best practice. In 2013/14 we will employ two new Dementia Care Specialist Nurses to provide additional resource to support the needs of this particular set of patients.

Our staff satisfaction index—which combines turnover, stability, sickness, vacancies and appraisal rates to create an overarching score—remains on track and is illustrated by our strong performance in the 2012 staff survey. In 2013/13 we will be reviewing our exit interview processes to make sure that we learn from leavers what we can do to improve staff satisfaction at the hospital and therefore improve our retention rate.

For more information about our clinical performance please read the Quality Report section.

Performance against CQUIN targets

The CQUIN payment framework enables commissioners to reward excellence by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

Chelsea and Westminster Hospital NHS Foundation Trust agreed its service framework with local commissioners at the start of 2012/13 and monitored progress against these priorities on a monthly basis. These priorities are based on local health need and include:

- Reducing avoidable death, disability and chronic ill-health from VTE
- Dementia screening, risk assessment and appropriate referral to a dementia specialist where required
- Providing realtime information on patient consultations and admissions to GPs
- Providing consultant assessment within 12 hours of emergency admission for both adults and children
- Improving patient experience results
- Ensuring that robust and complete data is submitted for the NHS safety thermometer
- Ensuring that 90% of prescribed drugs to either outpatients or those discharged into the care of their GP are chosen from the North West London integrated formulary
- Improving the identification of patients on the Acute Assessment Unit who are in the last year of life offering them the option of a care planning discussion and recording their preferences

- Ensuring that 90% of women are offered the BCG vaccination for newborn babies.

Overall, we achieved 99% of our CQUIN-related goals in 2012/13 for which we received a payment of £6,037k out of a maximum of £6,106k.

For more information about our performance against CQUINs please go the Quality Report section of this document.

How we measure up to inspection

Inspections are an important way for local people to be assured that publicly funded services are providing a high standard to the public. These inspections are conducted independently by skilled clinicians who can give a fair, accurate and unbiased view of the care delivered at that time and whether the organisation being assessed meets national standards. Should a service not meet national standards they can be asked to discontinue a service to protect patients.

The Care Quality Commission (CQC) conducted an unannounced inspection on three wards in July 2012 and the Trust was found to have met all five standards assessed on the day. These included:

- **Outcome 01:** People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run
- **Outcome 05:** Food and drink should meet people's individual dietary needs
- **Outcome 07:** People should be protected from abuse and staff should respect their human rights
- **Outcome 13:** There should be enough members of staff to keep people safe and meet their health and welfare needs
- **Outcome 21:** People's personal records, including medical records, should be accurate and kept safe and confidential

The CQC, in their public report available on their website www.cqc.org.uk, noted some very positive comments that patients made about the hospital. For example "this hospital saved my life" and "I cannot tell you how much I respect them for what they have done for me". One person said she "loved this hospital and that this hospital loved her."

However there is no room for complacency and the Trust will continue to ensure that even more is done to provide a safe and excellent care environment that engages patients and their families and ensure that the wider lessons from the recent Francis report are learned.

Changes to our hospital environment

The Trust has continued its multi-million pound investment programme to maintain and improve its facilities and meet rising demand for services. Improvements made to the environment in 2012/13 have included:

- A dedicated Children's Burns Unit

- A £3 million Diagnostics Centre bringing together endoscopy, cardiology and associated services

- Locating the dermatology and plastic surgery outpatient services within a single, refurbished unit

- Conclusion of the £9.8 million upgrade to the hospital's energy and resilience infrastructure to make it safer, more energy efficient and better value for money

- Completion of the first year of a three-year programme to replace flooring throughout the hospital

- A comprehensive upgrade of the hydrotherapy pool

- Upgrades to the hot water and security access control systems

- Refurbishment of public and staff washroom facilities

A five-year development plan is under way which will ensure that the Trust has state-of-the-art facilities to meet the needs of all its patients. Plans include:

- An improved and expanded A&E for adults and children, to help accommodate the additional patients that will be accessing the service following implementation of *Shaping a healthier future*

- Increased capacity for adult admissions to help accommodate *Shaping a healthier future*

- Ongoing improvements to adult outpatient areas

- Redeveloping Doughty House to repatriate non-clinical departments currently based on the main hospital site in order to free up space for clinical services and long-term plans including *Shaping a healthier future* and work with other NHS providers such as the Royal Brompton and Harefield NHS Foundation Trust

- A midwifery-led unit and birth centre, bringing together maternity and women's services on the third floor

When care is not so good: Responding to complaints

The Trust takes complaints very seriously. All new serious complaints and incidents are reviewed by the Executive team at their weekly meeting and lessons learned from complaints are shared across clinical divisions.

All complaints are logged and shared with directorates immediately, with quarterly clinical governance reporting. Trustwide quarterly reports and an annual report are prepared for the Patient and Staff Experience Committee and the Trust Board. The reports provide a summary and analysis of complaints raised through the Complaints team and an overview of changes made in response.

The Trust's Membership and Patient Advice & Liaison Service (M-PALS) is available to provide patients with information, support, advice and help in resolving concerns.

In line with national guidance, the Trust places its emphasis on local resolution of concerns raised. Staff are encouraged to do this by acknowledging the problem and where possible resolving the issue or providing an explanation. It is important that the complainant understands what the outcome will be and that this will meet their expectations. The completion of action plans is monitored and reported in the quarterly reports.

The new NHS complaints process no longer stipulates a timescale for responding to complaints but the Trust has set three levels of response depending on the nature, seriousness and complexity of the complaint.

Type 1 (less serious) complaints should be resolved within 10 working days, Type 2 complaints should be resolved within 25 working days, while Type 3 (more serious and often complex) complaints may require a longer timescale which should be discussed and agreed with the complainant.

It is essential that issues raised from complaints are dealt with in a sensitive and timely manner so as to prevent re-occurrence or escalation of incidents. We aim to respond to complaints within 25 working days from receipt of request. This year to date, 81% of the type 2 complaints received were responded to in 25 working days. This is against the Trust target of 90%.

During the past year considerable effort was made to improve how we manage complaints by responding to complainants on a more personal level and by improving the quality of responses. Complainants are now contacted by telephone to see how they would like their complaint to be investigated and to agree a timescale for resolution. Historically a complainant would simply have been sent an acknowledgement letter outlining the issue to be investigated. The Trust has determined that the initial contact and completion of Action Plans will be reported to the board and has determined a performance target of 90%.

For more information about complaints please read the Quality Report section of this document.

OUR STAFF

Our workforce

Key facts about the profile of the Trust's workforce include:

- When comparing the Trust's staff population with the overall ethnic profile of people living in London, we employ a more ethnically diverse range of staff
- Approximately 75% of staff are female
- 1% of staff have declared that they have a disability
- The age profile of the Trust workforce has remained the same as last year with 37% of staff in the 25–34 age bracket
- Of staff who have declared their religion, Christianity is the most widely practised faith

However, it should be noted that in many categories including religion, sexual orientation and disability, too few staff disclose information to make it statistically meaningful.

The annual sickness absence level in 2012/13 was 3.72%.

Action to inform, involve & consult with staff

The Trust is committed to keeping staff fully informed about everything that has an impact on their working lives at Chelsea and Westminster by providing them with information, consulting with them on key decisions and listening to their concerns.

A range of initiatives are in place to provide staff with information on matters of concern to them, consult staff or their representatives so that their views are taken into account in making decisions that are likely to affect their interests, encourage the involvement of staff in the Trust's performance and raise staff awareness of financial and economic factors affecting the Trust's performance.

- Executive Directors meet staff side (Trade Union) representatives at the monthly meeting of the Joint Management and Trade Union Consultative Committee (JMTUC), and the Director of Human Resources meets with the Staff-Side Chair on a fortnightly basis.
- Quarterly meetings of the Council of Governors, which includes elected staff representatives
- Communication with staff including a monthly staff magazine, a monthly face to face Team Briefing with executive directors which is disseminated through the line management structure to all staff within 48 hours, a blog from the Chief Executive published fortnightly and Daily Noticeboard email bulletin
- The Chief Executive holds a series of staff forums to engage with staff on Trust strategy
- Executive Directors are allocated specific areas of the Trust on a monthly basis and are expected to visit these areas, engage with staff and feedback any issues to the executive team

- In addition the Trust has staff networks (eg Creating Excellence Together, the Black, Asian Minority Ethnic network)

- A number of clinical summits with staff and commissioners to develop a forward looking strategic vision for the Trust, as part of a six month strategic review which began in January 2013

The Trust was ranked among the top 20% of acute Trusts in the 2012 NHS staff survey for staff engagement, for the fourth consecutive year and achieved the highest rating for staff reporting good communication between senior management and staff of any acute Trust.

NHS staff survey 2012

66% of staff completed the annual NHS staff survey 2012 (compared with a national average response rate for acute Trusts of 50%). This ranked our response as the highest acute Trust in London, and in the top 20% nationally.

The survey is structured around the NHS Constitution and two additional themes around staff satisfaction and equality and diversity. These pledges and themes are reported under 28 key findings (KFs).

Since 2009, a 'Staff Engagement Score' has been calculated, which includes staff's perceived ability to contribute to improvements at work, their willingness to recommend the Trust as a place to work/ receive treatment, and the extent to which staff feel motivated and engaged with their work. The Trust's engagement score was 3.87 (compared to 3.81 in 2011) which put us in the top 20% of acute Trusts in the country, for the fourth year in a row.

The Trust ranked in the top 20% of acute Trusts for 14 of the 28 key findings, and above average in a further 4. The Trust was in the bottom 20% for 2 key findings with another 5 below the average for an acute Trust. The Trust achieved the highest attained rating of any acute Trust for staff reporting good communication between senior management and staff.

When compared to the 2011 survey, the Trust improved on 16 key findings, while 11 deteriorated and one remained the same.

Areas of concern highlighted by the 2012 survey are around staff experiencing bullying and harassment or violence whilst at work, the percentage of staff receiving health and safety training in last 12 months, the percentage of staff reporting hand washing materials always being available and the percentage of staff experiencing discrimination at work in the last 12 months.

Two areas of concern continue from the 2011 results which are the percentage of staff receiving health and safety training in the previous 12 months, the percentage of staff reporting hand washing materials always being available and the percentage of staff experiencing discrimination at work. Action plans to address all areas of concern, with a renewed focus on the criteria that have continued since 2011, and improve on other key findings will be produced by departments across the Trust alongside an overall Trust plan.

Table 1: NHS staff survey response rate and job satisfaction key finding

	2011/12		2012/13		Improvement/ Deterioration
	Trust	National Average	Trust	National Average	
Response rate	61%	53%	66%	50%	+5% ↑

Table 2: Top and bottom ranking scores

These KF scores show where the Trust compares most favourably with other acute Trusts in England (top) and least favourably (bottom)

	2011/12		2012/13		Improvement/ Deterioration
Top 5 ranking scores	Trust	National Average	Trust	National Average	
KF21.* % of staff reporting good communication between senior management and staff	42%	26%	44%	27%	+2% ↑
KF1. % of staff feeling satisfied with the quality of work and patient care they are able to deliver	83%	74%	86%	78%	+3% ↑
KF24. Staff recommendation of the Trust as a place to work or receive treatment	3.89	3.50	4.02	3.57	+0.13 ↑
KF3. Work Pressure felt by staff (lower score better)	2.93	3.12	2.85	3.08	-0.08 ↑
KF6. % of staff receiving relevant job relevant training or development	83%	78%	85%	81%	+2% ↑

	2011/12		2012/13		Improvement/ Deterioration
Bottom 5 ranking scores	Trust	National Average	Trust	National Average	
KF28. % of staff experiencing discrimination at work in last 12 months (lower score better)	17%	13%	19%	11%	+2% ↓
KF10. % of staff receiving health and safety training in last 12 months.	64%	81%	66%	74%	+2% ↑
KF17*. % of staff experiencing physical violence from staff in last 12 months. (lower score better)	1%	1%	3%	3%	+2% ↓
KF27. % of staff believing the Trust provides equal opportunities for career progression or promotion	85%	90%	86%	88%	+1% ↑
KF12. % of staff saying hand washing materials are always available	61%	66%	55%	60%	-6% ↓

Note: Due to changes in the question structure, KFs marked * are not directly comparable with 2011 results. The most relevant comparison is shown for illustration.

	2011/12	2012/13	Improvement/ Deterioration
Largest local Changes since the 2011 Survey	**Trust**	**Trust**	
KF26: % of staff having equality and diversity training in last 12 months.	41%	49%	+8% ↑
KF24: Staff recommendation of the Trust as a place to work or receive	3.89	4.02	+0.13 ↑
KF11: % of staff suffering work related stress (lower score better)	28%	36%	+8% ↓

Future priorities and targets for the staff experience in 2013/14

- The Trust plans to engage with staff in accordance with the NHS Constitution.
- The Trust has established a multi-disciplinary focus group to inform the action plan focussed on the areas of concern.
- The Trust staff survey action plan will focus on addressing areas of concern from this year's staff survey, and build on areas of strength. Each division and directorate will have their own plan to work on to address "local" issues. Progress will be reported through the Trust's established communication systems.
- Beginning in April 2013, the Trust plans to introduce an internal survey for staff during the year, to ensure that action plans are being delivered and allow stronger engagement with staff on these plans.

Providing equal opportunities

We have an Equality & Diversity Policy to help explain the current equalities legislation and to ensure that staff are aware of their responsibilities as employees of the Trust and as frontline healthcare workers providing services to patients.

In addition, the Trust has a zero tolerance approach to bullying and harassment which is set out in our Harassment & Bullying Policy.

The Trust also considers requests for flexible working or reasonable adjustments through the respective policies for flexible working and the recruitment and retention of staff with disabilities.

The Trust has an Equality & Diversity Policy and a Recruitment and Selection Policy and Procedure which supports applications from disabled candidates to receive full and fair consideration. Specific support for Trust staff is provided through mandatory recruitment training for recruiting managers, as well as a policy for the recruitment and retention of staff with disabilities.

The Trust is a recognised '2 Ticks' employer. This status is awarded by Jobcentre Plus to employers that have made commitments to employ and develop the abilities of disabled staff.

Disabled staff, managers, Human Resources and Occupational Health staff advise on adjustments to support disabled staff including adjustments to job roles, working hours and environment, and provide additional training in line with the policy for the recruitment and retention of staff with disabilities.

Staff should have regular appraisals and any training needs or personal development opportunities should be identified during the employee's appraisal in accordance with the Trust's Appraisal Policy and Study Leave Policy.

Occupational Health performance

The Occupational Health service offers advice to staff on all aspects of health, safety and wellbeing at work, to ensure a safe working environment for staff, and provides a comprehensive range of services to maintain and improve the health and wellbeing of the workforce.

Since introducing the complimentary therapy service there has been a total of 105 appointments made for this service.

Staff have access to an Employee Assistance Programme which is a free and confidential service that provides staff with specialist information and advice on issues that are of concern to them.

The Occupational Health and Physiotherapy departments have also introduced a fast-track referral process to provide staff with quick access to physiotherapy services.

In 2012/13 a total of 670 Employment health and medical interviews were undertaken by the Occupational Health department to establish the fitness of staff to work and to ensure staff are appropriately immunised against infectious diseases in accordance with Department of Health guidance.

In addition, 815 management referrals/reviews were undertaken in 2012/13. Line managers continue to be the main source of referrals, requesting Occupational Health assistance with the management of sickness absence, rehabilitation and performance issues.

Occupational Health also provided support and guidance to staff who may be experiencing personal problems or work-related issues and as a result a total of 138 self-referrals were seen.

Remuneration report

The Remuneration Committee is a Committee of the Board of Directors which is appointed in accordance with the constitution of the Trust to determine the remuneration, allowances, pensions and gratuities or terms of service of the Executive Directors and rates for the reimbursement of travelling and other costs and expenses incurred by Directors.

The Board of Directors has delegated responsibility for agreeing remuneration, allowances, pensions and gratuities or terms of service for the Secretary and other Senior Managers. The Remuneration Committee does not determine the terms and conditions of office of the Chairman and Non-Executive Directors. These are decided by the Council of Governors at a General Meeting.

The membership of the Remuneration Committee includes the Trust Chairman, Professor Sir Christopher Edwards, and five Non-Executive Directors—Sir John Baker, Professor Richard Kitney, Jeremy Loyd, Sir Geoffrey Mulcahy and Karin Norman.

The meeting is also attended where possible by the Chief Executive and the Director of Human Resources for the purpose of providing advice or services to the committee that materially assist the committee in the consideration of the matters before them, other than the consideration of their own remuneration, allowances, pensions and gratuities or terms of service.

There were three committee meetings in 2012/13—28 May 2012, 28 Jun 2012 and 25 Oct 2012. All six members of the committee attended the May meeting with the Director of Human Resources in attendance. Four members of the committee attended the June meeting (Professor Sir Christopher Edwards, Sir John Baker, Professor Richard Kitney and Jeremy Loyd) with the Chief Executive and Director of Human Resources in attendance. Five members of the Committee attended the meeting in October (Professor Sir Christopher Edwards, Sir John Baker, Karin Norman, Sir Geoff Mulcahy and Jeremy Loyd) with the Chief Executive and the Director of Human Resources in attendance.

In order to assess whether performance conditions were met for those officers under the remit of the Committee, appraisals are conducted regularly and progress is assessed against personal and corporate objectives, long and short term.

At the 28 Jun 2012 meeting it was agreed that as directors and others on ‘spot salaries’ had not received the equivalent of increments payable to Agenda for Change (AfC) staff it was agreed that a pay inflation of 2% per annum for the last two years should be paid to the Executive Directors and five other senior managers who are on ‘spot’ salaries with effect from 1 Apr 2012.

Remuneration consists mainly of salaries and pension benefits in the form of contributions to the NHS Pension Fund which are not subject to performance conditions.

For a breakdown of salary and pension entitlements of senior managers, please see note 5.6 of the signed accounts. Accounting policies for pensions and other retirement benefits are set out in note 1.5 of the accounts.

Hutton Disclosure—audited information

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid Director in the organisation and the median remuneration of the organisation’s workforce.

The banded remuneration of the highest paid director in the Trust in the financial year 2012/13 was £220,000–£225,000 (2011/12 £200,000–£205,000). This was 6.2 times the median remuneration of the workforce (2011/12 5.7 times), which was £36,118 (2011/12 £35,609).

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

The median ratio has increased in 2012/13 due to a change in the highest paid director in the year.

Expenses and tax arrangements disclosure

During the year 2012/13 there were no expenses in relation to the patient, staff and public governors and a total of £2.6k of expenses in relation to the directors and non-executive directors. These expenses were predominantly travel costs in relation to meetings or conferences.

Following on from the Review of Tax Arrangements of Public Sector Appointees published by the Treasury on 23 May 2012, NHS bodies are required to disclose specific information about off payroll engagements. The Trust had in place 25 off payroll engagements at a cost of over £58,200 per annum as at 31 Jan 2012, of which none had come onto the Trust's payroll and 3 had come to an end by 31 Mar 2013. There were 7 new off-payroll engagements between 23 Aug 2012 and 31 Mar 2013 at a rate of more than £220 per day and more than six months, and within the total group of off payroll arrangements in place as at this date assurance was requested and received from 16 individuals relating to income tax and National Insurance obligations. No contracts from within this number have been terminated as a result of assurance not being received. The Trust updated the standard contractual agreement for all external contractors in Oct 2012 to include clauses giving the Trust the right to seek assurance in relation to income tax and National Insurance obligations, therefore all new contracts for off payroll arrangements are covered by this clause.

Signed by

Tony Bell OBE
Chief Executive
28 May 2013

LOOKING TO THE FUTURE

Long-term developments

Shaping a healthier future

More than 80% of people responding to the *Shaping a healthier future* public consultation on changes to NHS services in North West London supported Option A.

Ipsos MORI announced the results of the consultation, which took place from July to October 2012, at a public meeting on 28 November.

In total 83% of respondents supported Option A which proposes there should be five major hospitals with full A&E departments in North West London including Chelsea and Westminster.

More than 11,000 people completed a postcard to register their support for the 'Safe in our Hands' campaign which was run by Chelsea and Westminster during the public consultation to encourage Foundation Trust members, local residents and staff to vote for Option A.

More than 6,500 people also signed an online petition in support of Option A which was set up by Chelsea and Westminster Foundation Trust governors—elected representatives of patients, members of the public and staff.

A considerable amount of time and effort was made by staff and Foundation Trust members to canvass public opinion by successfully conveying the clinical case for change.

The Joint Committee of Primary Care Trusts in North West London made a final decision on 19 February 2013 to uphold the results of the public consultation, designating Chelsea and Westminster as a major hospital with a full A&E service.

Chelsea and Westminster Hospital NHS Foundation Trust is now working to develop the Outline and Full Business Cases that will include the required facility changes and staffing increase to ensure that the additional numbers of patients will be able to be accommodated while maintaining safe and excellent clinical services. This will require working closely with out of hospital partners in primary and community care and, where appropriate, non-medical partners.

Chelsea Children's Hospital

We want an environment in which we provide paediatric services to match the high standards of care we already deliver. The Chelsea Children's Hospital, based on the First Floor of the main hospital building, will officially open in 2014 and will eventually include:

- A purpose-built day case and recovery unit (Saturn Ward) for children and young people
- Four brand new state-of-the-art dedicated children's theatres, a first stage recovery unit and high dependency unit.
- A new surgical/gastroenterology ward (Mercury Ward)
- A dedicated Children's Burns Unit
- A new Children's Outpatients and Medical Day Unit
- A new adolescent ward (Jupiter Ward)

- A new children's acute medical ward (Neptune Ward) and a dedicated Children's Assessment Unit (CAU) for short-stay observation and treatment.

Having these dedicated children's facilities all in one area will help us deliver a better patient experience to families accessing our services.

Potential partnership with West Middlesex University Hospital NHS Trust

Following an options appraisal process in 2012/13, West Middlesex University Hospital NHS Trust Board agreed that Chelsea and Westminster Hospital NHS Foundation Trust were the preferred bidder to explore a potential partnership to achieve Foundation Trust status. A future partnership offers the potential to build on the high quality care that we currently deliver and develop our services in an innovative and integrated way for our patients.

Ahead of any formal approval of this process, which would take place in 2013/14, both organisations remain committed to delivering high quality clinical services while the partnership option is explored. This includes delivering the recommendations of the *Shaping a healthier future* programme in conjunction with commissioners and local health and social care providers.

Principal risks and uncertainties facing the Trust

The Trust has effective mechanisms in place to manage risk, in accordance with its risk management policy and strategy, supported by two committees with Board accountability—the Audit Committee and the Assurance Committee.

Areas of uncertainty and risk in 2013/14 include continued financial pressures and the potential impact of proposed NHS reforms, both nationally and locally in North West London. This relates to the reconfiguration of A&E services and London as a whole including the provision of tertiary paediatrics, HIV and burns services.

There has been a change in the commissioning of public health services from Primary Care Trusts to Local Authorities from 1 April 2013. How sexual health services are commissioned and the tariff across London is uncertain which could present a significant risk to the Trust's income. In addition, as an open access service there are potentially clinical risks if patients are unable to obtain advice and treatment due to lack of funding agreements. The Trust is working with Local Authorities and other key stakeholders to clarify funding arrangements.

There are uncertainties around the impact of the practical implementation of the Health and Social Care Act, in particular the transfer of responsibility for commissioning services to GPs, the relaxation of the private patient income cap, more choice for patients and increased competition.

The overall Trust strategy has taken these issues into account and plans are in place to mitigate and/or benefit from these changes.

Strategic plans

There is work currently underway that is reassessing the overall vision for the organisation in times of unprecedented NHS change. This vision will be agreed at Trust Board level by the end of the first quarter of 2013/14.

In 2013/14 our strategic priorities will be:

- To deliver services that are accountable for population health outcomes
- To integrate services inside and outside of hospital
- To provide the right mix of unscheduled and scheduled services
- To embed a relentless focus on improving safety, patient experience, clinical effectiveness and operational efficiency.

Performance and efficiency

We are now identifying our cost improvement plans (CIPs) for 2013/14 and beyond as part of the High Quality Planning process. The proposed 2013/14 CIP target is £16.9 million and assumes that all areas make a minimum 4% CIP. There is a need to make a year-on-year CIP in order to invest in services and infrastructure but which does not have a negative impact on patient care, the importance of which has been emphasised by the Francis Inquiry Report. Currently £11.7 million worth of schemes have been identified against the £16.9 million 2013/14 CIP target (69%).

Key service developments in 2013 and beyond

2013 marks a very special moment in the Trust's history as the main hospital site celebrates its 20th anniversary.

It is fitting, therefore, that this is celebrated with major investments to key clinical services. These include the opening of the Chelsea Children's Hospital in 2014 which will eventually include:

- A purpose-built day case and recovery unit (Saturn Ward) for children and young people
- Four brand new state-of-the-art dedicated children's theatres, a first stage recovery unit and high dependency unit.
- A new surgical/gastroenterology ward (Mercury Ward)
- A dedicated Children's Burns Unit
- A new Children's Outpatients and Medical Day Unit
- A new adolescent ward (Jupiter Ward)
- A new children's acute medical ward (Neptune Ward) and a dedicated Children's Assessment Unit (CAU) for short-stay observation and treatment.

This work will enable us to co-locate children's services on one floor in the hospital, making it easier for families and visitors to access our full portfolio of children's services.

The London Specialised Commissioning Group (SCG) has also approved £2.4 million funding for the re-development of the adult burns service. This work will be completed by the end of 2013.

STATUTORY INFORMATION

A brief history of the Trust

Chelsea and Westminster Hospital opened in May 1993 on the former site of St Stephen's Hospital. It replaced five hospitals—St Stephen's, St Mary Abbots, Westminster Children's, Westminster and West London. Chelsea and Westminster Hospital NHS Foundation Trust was founded on 1 Oct 2006 under the Health and Social Care (Community Health and Standards) Act 2003.

Quality

The Trust has reviewed the four areas of the quality governance framework—strategy, capabilities and culture, processes and structures, and measurement.

In each area, Trust practice has been outlined and consideration has been given to developments to strengthen quality governance further.

The Trust considers that there are robust structures and processes in place to ensure required standards are met, action is taken to address sub-standard performance, there are plans to drive continuous improvement which is based on best practice and that risks to quality of care are identified and managed.

Areas for development have been identified and these include continuing to focus on data assurance and improving the reports on performance to the Board and also a review of how clinical audit is being used to assess and drive quality.

Further information is provided in the Quality Report and the Annual Governance Statement.

Regulatory ratings

Explanation of ratings

Financial risk rating: When assessing financial risk, the Foundation Trust regulator Monitor assigns a risk rating using a scorecard which compares key financial metrics on a consistent basis across all NHS Foundation Trusts.

The risk rating is intended to reflect the likelihood of a financial breach of the terms of authorisation.

The financial indicators used to derive the financial risk rating incorporate five individual ratings which are each rated from 1 (high risk) to 5 (low risk).

Governance risk rating: Monitor's assessment of governance risk is based predominantly on NHS Foundation Trusts' plans for ensuring compliance with the terms of their authorisation but will also reflect historic performance where this may be indicative of future risk.

Monitor considers eight elements when assessing the governance risk rating—legality of constitution, growing a representative membership, appropriate Board roles and structures, service performance, clinical quality and patient safety, effective risk and

performance management, co-operation with NHS bodies and local authorities, and provision of mandatory services.

Monitor rates governance risk using a graduated system of green, amber/green, amber/red and red, where green indicates low risk and red indicates high risk.

Summary

Governance risk rating performance

In 2012/13 the Trust was rated green for governance. The plan for 2012/13 was for an amber/green rating.

Finance risk rating performance

In 2012/13 we achieved a financial risk rating of 5, a better performance than our plan which was to achieve a rating of 4.

2012/13	Annual Plan	Q1	Q2	Q3	Q4
Financial risk rating	4	4	4	4	5
Governance risk rating	GREEN	GREEN	GREEN	GREEN	GREEN

2011/12	Annual Plan	Q1	Q2	Q3	Q4
Financial risk rating	4	3	4	5	5
Governance risk rating	AMBER/GREEN	GREEN	GREEN	GREEN	GREEN

Counter fraud policies and procedures

The Trust has a Counter Fraud Policy for dealing with suspected fraud and corruption and other illegal acts involving dishonesty or damage to property.

Nominated staff who Trust staff can contact confidentially if they suspect a fraudulent act are the Director of Finance and the Local Counter Fraud Specialist (LCFS).

Health and safety

The number of incidents reported to the Health & Safety Executive decreased slightly from 27 in 2011/12 to 26 in 2012/13.

Environmental matters

The Trust pledged to reduce its carbon footprint by joining the Carbon Trust's NHS Carbon Management programme in May 2007.

Ensuring our environmental sustainability forms part of a Trust corporate objective and we have committed to improve our environmental sustainability by exceeding the NHS national target of 10% carbon reduction by 2015.

A £9.5 million project to overhaul the hospital's infrastructure was completed in 2011/12.

This transformation of the way in which electricity, heating and cooling is supplied to the hospital will reduce the Trust's carbon footprint and make us self-sufficient in terms of the power needed to keep services running smoothly.

In addition, all staff are encouraged to help cut carbon emissions and reduce energy bills by taking simple steps to be more energy efficient.

And further work has taken place in 2012/13 to centralise our printing functions to be more efficient and help reduce the unnecessary printing of paper.

Action to inform, involve and consult with staff

See the 'Our staff' section on page 122 for details.

Disclosure of audit information

So far as the directors are aware, there is no relevant audit information of which the auditors are unaware.

The directors have taken all steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

The directors are responsible for the maintenance and integrity of the corporate and financial information included on the Trust's website.

Legislation in the United Kingdom governing the preparation and dissemination of financial information differs from legislation in other jurisdictions.

Better Payment Practice Code

The Better Payment Practice Code requires the Trust to pay all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later, unless other payment terms have been agreed with the supplier. The Trust's compliance with the Code is set out in the Notes to the Accounts.

Going concern

The financial performance and position of the Trust, together with the factors likely to affect its future development and the principal risks and uncertainties it faces, are described in the Directors' Report.

After making enquiries, the directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future.

For this reason, they continue to adopt the going concern basis in preparing the accounts.

GOVERNANCE REPORT

NHS Foundation Trust Code of Governance

Chelsea and Westminster Hospital NHS Foundation Trust is committed to effective, representative and comprehensive governance which secures organisational capacity and the ability to deliver mandatory goods and services. The Trust's governance arrangements are reviewed yearly against the provisions of Monitor's Code of Governance to ensure the application of the main and supporting principles of the Code as a criterion of good practice.

It is the responsibility of the Board of Directors to confirm that the Trust complies with the provisions of the Code or, where it does not, to provide an explanation which justifies departure from the Code in the particular circumstances.

For the year ending 31 Mar 2013 Chelsea and Westminster Hospital NHS Foundation Trust complied with all the provisions of the Code of Governance published by Monitor in March 2010 with the exception of Code provision C.1.12. An independent external adviser should not be a member of or have a vote on the nominations committee(s) which is inconsistent with Chelsea and Westminster Hospital NHS Foundation Trust constitution which specifies that another person nominated by the Nominations Committee will be invited to act as an independent assessor to the Nominations Committee for the appointment of Non-executive Directors.

Board of Directors

Composition of the Board

The Board has six Non-executive Directors (including the Chairman) and 5 Executive Directors (including the Chief Executive)—the Director of Governance and Corporate Affairs attends Board meetings as Company Secretary.

The appointment of the Chairman and appointment/reappointment of Non-executive Directors is approved by the Council of Governors. The appointment of the Chief Executive is by the Non-executive Directors, subject to approval by the Council of Governors.

See 'Board of Directors-Who's Who' for details of the Board including each Director's name, role or job title, responsibilities, a brief description of their background and length of appointment (Non-executive Directors only).

Balance of Board membership & independence

The Board of Directors is satisfied that its balance of knowledge, skills and experience is appropriate to the Board and its sub-committees.

The Board has evaluated the circumstances and relationships of individual Non-executive Directors which are relevant to the determination of the presumption of independence.

The Board determines all of its Non-executive Directors to be independent in character and judgement. One Non-executive Director has been appointed as a representative of Imperial College London, the Trust's partner in medical education. However, the Board remains confident that, in spite of this relationship, this Director's judgement is not likely to be affected.

Performance evaluation of the Board of Directors and its committees

The annual appraisal of the Chairman involves collaboration between the Senior Independent Director and the Deputy Chairman of the Council of Governors to seek the views of both Executive Directors and governors. Executive Directors have an annual appraisal with the Chief Executive. The performance of Non-executive Directors is evaluated annually by the Chairman. The Audit Committee and Assurance Committees undertake a yearly review of their effectiveness, which is reported to the Board.

Access to register of directors' interests

Members of the public can gain access to the register of directors' interests by making a request to the Foundation Trust Secretary, Chelsea and Westminster Hospital NHS Foundation Trust, 369 Fulham Road, SW10 9NH, via email ftsecretary@chelwest.nhs.uk or on 020 3315 6716.

Board meetings

The Board meets on average once a month. Special meetings are organised as and when required. There were 9 ordinary meetings in 2012/13.

No special meetings were held.

Directors' attendance at Board meetings 2012/13

Non-executive Directors	Ordinary Meetings
Prof Sir Christopher Edwards	9/9
Sir John Baker	8/9
Prof Richard Kitney	8/9
Jeremy Loyd	8/9
Sir Geoff Mulcahy	8/9
Karin Norman	8/9

Executive Directors	Ordinary meetings
Tony Bell OBE[19]	5/5
Heather Lawrence OBE[20]	3/3
Mike Anderson[21]	8/9
Lorraine Bewes	9/9
Thérèse Davis	9/9
Zoë Penn[22]	1/1
David Radbourne[23]	8/9
Catherine Mooney [24]	9/9

Significant commitments of the Trust Chairman

The Chairman is a Senior Research Fellow at Imperial College London and Chairman of the Council of the British Heart Foundation. He is also the Chairman of Cluff Geothermal and a Trustee of the Planet Earth Institute. He is the patron of Tom's Trust.

19 Attended Board meetings from Sep 2012
20 Attended Board meetings until Jul 2012
21 Attended Board meetings as Acting Chief Executive Jul–Sep 2012 and as Medical Director Sep 2012–Feb 2013
22 Attended Board meetings from Mar 2013
23 Attended Board meetings as Interim Chief Operating Officer Apr–Dec 2012 and as substantive Chief Operating Officer Jan–Mar 2013
24 Attends Board meetings as Company Secretary

Board of Directors—Who's Who

Non-executive Directors

Professor Sir Christopher Edwards, Chairman: Professor Edwards was appointed in November 2007 and reappointed for a further three years in November 2010. He was the first Principal of Imperial College School of Medicine from 1995 to 2000 before becoming Vice-Chancellor of the University of Newcastle upon Tyne where he led a major restructuring to make it one of the top universities in the UK. During a distinguished medical and academic career, Professor Edwards has held numerous senior positions including President of the Association of Physicians of Great Britain and Ireland and Chairman of the Council of Heads of Medical Schools. He was knighted in June 2008 and appointed as the first Chairman of NHS Medical Education England in December 2008. He is also Chairman of the Council of the British Heart Foundation and Cluff Geothermal. He chairs the Finance & Investment Committee.

Sir John Baker CBE: Sir John's appointment as a Non-executive Director Designate was approved by the Council of Governors in December 2010. He became a full Non-executive Director in November 2011 for a period of three years. Sir John has had a career in both public and private sectors. He is currently a Director of Renewable Energy Holdings Plc. He spent 10 years dealing with transport policy as a senior civil servant, followed by 10 years leading an urban regeneration and social housing agency, before becoming Managing Director of the Central Electricity Generating Board in 1979 and leading the management of the UK electricity privatisation and restructuring programme. He was Chief Executive and then Chairman of National Power PLC from 1989 to 1997 and he was Chairman of the World Energy Council from 1995 to 1998. Outside the business arena Sir John is Chairman of the Governing Body of Holland Park School and Chairman of the Board of Trustees of The Mayor of London's Fund for Young Musicians. He is currently the Vice Chair of the Board of Directors, Chair of the Audit Committee and Senior Independent Director.

Professor Richard Kitney OBE: Professor Kitney was reappointed for a term of one year in October 2012. He is Professor of Biomedical Systems Engineering and Dean of the Faculty of Engineering at Imperial College. A leading authority on the use of IT in healthcare, Professor Kitney is Chairman and Director of Visbion Ltd. He is a member of the Assurance Committee and the Audit Committee.

Jeremy Loyd: Jeremy's appointment as a Non-executive Director Designate was approved by the Council of Governors in December 2010. He became a full Non-executive Director in November 2011 for a period of three years. Jeremy is currently a Non-executive Director of UCL Cancer Institute Research Trust and the Marine Management Organisation. He was formerly Director and General Manager of Carlton Television, Managing Director of Capital Radio and a Non-executive Director of several other companies in both the UK and USA. Jeremy was also Deputy Chairman of Blackwells, the academic information distributer and retailer. He was the Chair of the Patient Experience Committee and is now a member of the Patient and Staff Experience Committee. He is a member of the Assurance Committee.

Sir Geoffrey Mulcahy: Sir Geoffrey's appointment as a Non-executive Director Designate was approved by the Council of Governors in December 2010. He became a full Non-executive Director in November 2011 for a period of three years. Sir Geoffrey is Chairman of Javelin Group (a retail consultancy), a trustee of CCCS (a debt counselling charity) and

an operating partner of GLP (an investment adviser). Until 2002 he was Chief Executive of Kingfisher plc, a retail business operating in 14 countries worldwide with brands in the UK including B&Q, Comet, Superdrug, and Woolworths. He retired after demerging Kingfisher into three separately quoted businesses. Previously he worked for British Sugar, Norton Company (a US engineering company), and Esso. He has been a Non-executive Director of a number of companies including BT and Intercontinental Hotels (previously Bass plc). He is a member of the Finance and Investment Committee and the Audit Committee.

Karin Norman: Karin was was originally appointed in 2005 and was reappointed for a term of one year in October 2012. She worked in investment banking in London and New York as a fixed income specialist, advising on investments, risk and capital management, and structured finance. She was a Non-executive Director of the NHS Pensions Agency and is currently a member of the Audit Committee and the Investment Committee for Parkinson's UK, a Trustee of the Nursing and Midwifery Council. She is the Chair of the Assurance Committee and a member of the Finance and Investment Committee.

Executive Directors

Tony Bell OBE, Chief Executive: Tony Bell OBE was appointed as Chief Executive in May 2012 and took up post on 3 September 2012. He has 30 years' experience of working in the NHS at all management levels, having originally trained as a registered general nurse, and was awarded the OBE for services to healthcare in 1996. He was Chief Executive of Royal Liverpool & Broadgreen University Hospitals NHS Trust, a major university teaching hospital, from 2007–12 and he was previously Chief Executive of Alder Hey Children's Hospital in Liverpool.

Lorraine Bewes, Director of Finance: Prior to her appointment in May 2003, Lorraine was Director of Performance at University College London Hospitals NHS Foundation Trust and Deputy Director of Finance at Hammersmith Hospitals NHS Trust. She joined the NHS in 1991 following a successful commercial accountancy career, during which she worked at ITN and WH Smith Television Services. Lorraine has led the early implementation of service line reporting in the NHS. She is a graduate of Oxford University and is a chartered accountant.

Thérèse Davis, Chief Nurse and Director of Patient Flow & Patient Experience: Thérèse rejoined the Trust as Interim Director of Nursing in June 2010, having been Director of Nursing at the Trust a number of years previously. She was appointed to the substantive post of Chief Nurse and Director of Patient Experience and Flow in February 2011. Thérèse has been a nurse in London for the past 26 years, originally specialising in medical and oncology nursing, and a Director of Nursing for the past 13 years including at the Royal Free Hospital in Hampstead. Her successes include implementing systems and initiatives to improve the experience patients receive whilst in hospital. She has also led many initiatives to enhance patient safety and effectiveness, setting goals and targets to achieve positive change. Thérèse has a degree in nursing from Manchester University and an MBA from Henley College, for which she received an NHS bursary.

Zoë Penn, Medical Director: Zoë Penn was appointed as Medical Director in March 2013. She was previously Divisional Medical Director for Women, Neonatal, Children & Young People, HIV, GUM & Dermatology Services and is a Consultant Obstetrician by background. Miss Penn has been a consultant with the Trust since 1996, during which time she has held a number of positions including Clinical Lead for Gynaecology and Clinical Director for Women and Children's Services.

David Radbourne, Chief Operating Officer: David joined the Trust in April 2012 as interim and in December 2012 as substantive Chief Operating Officer having previously been Director of Corporate Performance and Transition at NHS North East London PCTs. David joined the NHS as a management trainee in 1995 and has held a number of senior roles in acute Trusts, commissioning bodies and at the Department of Health and NHS Modernisation Agency. David's successes include helping to achieve successful authorisation as a Foundation Trust and early achievement of the 18 weeks and cancer access standards at Milton Keynes NHS Foundation Trust. In his most recent role at NHS North East London PCTs, in addition to improving performance across North East London, he led on the implementation of the NHS reforms to strengthen commissioning and establish Clinical Commissioning Groups. David is a graduate of the University of Wales and holds an Executive MBA.

Catherine Mooney, Director of Governance & Corporate Affairs: Before being appointed in March 2006, Catherine was Clinical Governance Manager at Hammersmith Hospitals NHS Trust for two years and prior to that was Chief Pharmacist at St Mary's NHS Trust for 15 years. She attends Board meetings as Company Secretary.

Executive Directors who resigned in 2012/13 were as follows:

Heather Lawrence OBE, Chief Executive until 23 July 2012: Heather has over 25 years' experience at NHS Trust Board level, having served as Chief Executive of Hounslow and Spelthorne Community and Mental Health Trust and North Hertfordshire NHS Trust before being appointed Chief Executive at Chelsea and Westminster in May 2000. Her management experience spans all sectors of healthcare and includes major service change including the development of innovative services, service re-design, developing an academic department, and closure of services. Heather chaired the North West London Critical Care Network and the Operational Board of the North West London Health Innovation and Education Cluster (HIEC). She was NHS Employers' lead negotiator for the three-year pay deal for staff on Agenda for Change. She was a member of the Government's Nursing and Midwifery Commission through which she and 15 other members advised the Government on the future roles of nurses and midwives. Heather is a Fellow of the Chartered Institute of Personnel and Development. She was awarded the OBE in the New Year's Honours 2009 list for services to healthcare.

Dr Mike Anderson, Medical Director until 1 Mar 2013: Dr Anderson was appointed in Summer 2003. Previously, he was a Consultant Physician and Gastroenterologist at West Middlesex Hospital where he also held the post of Medical Director. He is an Honorary Clinical Senior Lecturer of Imperial College and continues in active clinical practice as a Consultant Gastroenterologist.

Amanda Pritchard, Deputy Chief Executive (Director of Integrated Service Delivery & Modernisation) until 13 April 2012 : Prior to her appointment in September 2006, Amanda worked in the Prime Minister's Delivery Unit. She was previously Acting Director of Strategy & Service Development and General Manager for the Surgery and Anaesthetics & Imaging Directorates at Chelsea and Westminster, and Assistant Director of Critical Care & Ambulatory Services at West Middlesex Hospital.

Audit Committee

Membership & attendance

The Audit Committee is chaired by Sir John Baker, Non-executive Director, and includes 2 other Non-executive Directors, Sir Geoff Mulcahy and Prof Richard Kitney. It met 4 times in 2012/13. Sir John Baker attended 4 meetings, Sir Geoff Mulcahy attended 3 meetings, Prof Richard Kitney attended 2 meetings.

How the Committee discharges its responsibilities

The Audit Committee assures the Board of Directors that probity and professional judgement are exercised in all financial matters.

It advises the Board on the adequacy and effectiveness of the Trust's systems of internal control and its arrangements for risk management, control and governance processes, and securing economy, efficiency and effectiveness (value for money). It prepares an annual report for the Board.

Policy for safeguarding the external auditors' independence

Appointment of the external auditors to non-audit work is considered by the Chair of the Audit Committee prior to award of contract. During the financial year the Trust awarded contracts for non-audit work to its external auditors for two areas of support. Firstly, to provide expert advice on a potential property transaction and secondly to provide support to the Trust on the first phase of due diligence for the potential West Middlesex Hospital transaction. Both contracts were awarded following a competitive process and evaluation of tender submissions from Deloitte and other bidders. The external auditors' objectivity and independence have been safeguarded through segregation of roles between the team advising on the audit and the teams supporting the transactions.

Responsibility for preparing the annual accounts

The Chief Executive is the Trust's designated Accounting Officer with the duty to prepare the accounts in accordance with the NHS Act 2006.

Nominations Committees

There are two Nominations Committees.

Nominations Committee of the Council of Governors for the appointment of Non-executive Directors

The Nominations Committee is a Standing Committee of the Board of Directors which makes recommendations to the Appointments Committee for the Chief Executive post (subject to approval of the Council of Governors), other Executive Directors (board members) and the Secretary. The Nominations Committee comprises the Chairman of the Foundation Trust and the Chief Executive (except for consideration of his/her own appointment, re-appointment or removal) as well as members drawn from a membership pool of the Non-executive Directors of the Board of Directors.

This Nominations Committee identifies appropriate candidates for Executive Director vacancies through a process of open competition which takes account of an evaluation of the balance of skills, knowledge and experience of the Board and makes recommendations for shortlisted candidates to the Board's Appointments Committee which consists of the Chairman, Chief Executive (except for his/her own appointment) and other Non-executive Directors. An external adviser may be invited to give advice to the Appointments Committee.

In 2011/12 the Committee agreed the job description, person specification, process for appointment and long listing of applicants for the post of Chief Executive. This is described in the Trust Annual Report 2011/12. Meetings in 2012/13 consisted of a shortlisting meeting on 16 April 2012, attended by Prof Sir Christopher Edwards , Sir John Baker, Prof Richard Kitney, Jeremy Loyd, Geoff Mulcahy and Karin Norman and the Appointments Committee which undertook a formal interview with the candidates on 2 May 2012 attended by Prof Sir Christopher Edwards , Sir John Baker, Prof Richard Kitney, Jeremy Loyd and Geoff Mulcahy and an external adviser. Mark Gammage was in attendance at both meetings in his capacity as Director of HR. The appointment of Tony Bell OBE as Chief Executive was approved by the Council of Governors at its meeting on 3 May 2012.

The Chief Executive and Chairman, on behalf of the Board, agreed the job description, person specification and process for appointment of the Chief Operating Officer and Medical Director.

The Nominations Committee met in October 2012 and was attended by Christopher Edwards , Sir John Baker, Karin Norman, Geoff Mulcahy and Jeremy Loyd.

An appointment was made in December 2012 for the Chief Operating Officer post and in March 2013 for the Medical Director post. Both interviews involved at least one external adviser.

Council of Governors

How the Board of Directors and the Council of Governors operate

The Council of Governors represents the interests of the local community—patients, public and staff who are Foundation Trust members—and shares information about key decisions with Foundation Trust members. The Council of Governors is not responsible for the day-to-day management of the organisation which is the responsibility of the Board of Directors. There are corporate governance arrangements in place incorporated within the Reservation of Powers to the Board and Delegation of Powers outlining which decisions are to be delegated to the executive management. These include: contracts, tendering procedures, security of the Trust's property, monitoring and ensuring compliance with Department of Health directions on fraud and corruption, delegated approval limits, budget submission, annual accounts and reports, banking arrangements, payroll, borrowing and investment, risk management and insurance arrangement.

Key roles of the Council of Governors include:

- Appoint or remove the Chairman and other Non-executive Directors and approve the appointment (by Non-executive Directors) of the Chief Executive

- Decide the remuneration, allowances and other terms and conditions of office of Non-executive Directors

- Appoint or remove the Foundation Trust's Financial Auditors

- Review and develop the Trust's Membership Development and Communication Strategy

Composition of the Council of Governors

There are 35 governors including:

- Chairman (appointed)—also Chairman of the Board of Directors
- 6 Staff (elected)—1 each from 6 staff constituencies
- 8 Public (elected)—2 each from 4 local boroughs
- 10 Patients (elected)—patients treated at the hospital in the last 3 years or their carers
- 10 Nominated Representatives (appointed)—nominated from 10 partnership organisations

The Council of Governors meets at least quarterly. There were 5 meetings in 2012/13.

Executive and Non-executive Directors are invited to attend. Details of their attendance are in the table 'Directors' attendance at Council of Governors meetings 2012/13'. Details of Governors' attendance at meetings are in the table 'Governors—Who's Who'.

Governors' initial terms of office commenced on the day that the Foundation Trust was licensed, 1 October 2006. Both elected and appointed governors normally hold office for a period of 3 years and are eligible for re-election or reappointment at the end of that period.

Elections held during 2012/13

An election was held in 2012/13 to fill a vacant seat in the patient constituency.

- Walter Balmford—elected
- Thomas Church—elected
- Alan Cleary—re-elected
- Susan Maxwell—re-elected
- Wendie McWatters—re-elected
- Tera Younger—elected

An election was held in 2012/13 to fill a vacant seat in the public constituency.

- Hammersmith and Fulham Area 2—Christine Blewett—re-elected
- Wandsworth Area 2—Steve Worrall—elected

An election was held in 2012/13 to fill a vacant seat in the following classes of the staff constituency:

- Allied Health Professionals, Scientific & Technical—James Dennis—elected
- Contracted—Julie Armstrong—elected
- Medical and Dental—Professor Brian Gazzard—re-elected

No nominations were received for the following constituencies:

- Public—Kensington and Chelsea Area 1
- Staff—Management

Name and Constituency/Organisation)	Date elected or appointed	Attendance at Council Meetings 2012/13
Prof Sir Christopher Edwards (Chairman)	Nov 2007	5/5
Adams, Eddie[25]	Nov 2010	0/0
Balmford, Walter	Nov 2012	2/2
Birch, Chris (Patient)	Jun 2010	5/5
Blewett, Christine (Public—Hammersmith & Fulham 2)	Nov 2012	5/5
Browne, Nicky (The Royal Marsden NHS Foundation Trust)	Dec 2006	4/5
Dr Cadman, Anthony (Patient)	Nov 2010	4/5
Cass, Fergus (Appointed—NHS Kensington and Chelsea)[26]	Jul 2011	1/5
Cass-Horne, Cass J (Patient)[27]	Nov 2009	3/3
Church, Tom	Nov 2012	2/2
Cleary, Alan (Patient)	Nov 2012	4/5
Coolen, Edward (Patient)[28]	Nov 2009	1/3
Culhane, Samantha (Public—Hammersmith & Fulham 1)	Jun 2010	3/5
Dale, Carol (Staff—Support, Admin & Clerical)[29]	Nov 2009	2/3
Dennis, James	Nov 2012	2/2
Gazzard, Prof Brian (Staff—Medical and Dental and Deputy Chairman)[30]	Nov 2012	4/5
Glazebrook, Rosie (Appointed—NHS PCT Hammersmith & Fulham)[31]	Nov 2009	1/5
Higham, Jenny (Appointed—Imperial College London)	May 2011	4/5
Hodson-Pressinger, Anne (Patient)	Nov 2011	3/5
Jeremiah, Melvyn (Public—Westminster 2)	Nov 2010	3/5
Jesus, Jacinto (Staff—Contracted)[32]	Nov 2009	2/3
Lewis, Martin (Public—Westminster 1)	Nov 2010	4/5
Mangold, Catherine (Staff—Nursing and Midwifery)	Nov 2010	5/5
Marrash, William (Patient)	Nov 2010	5/5
Maxwell, Susan (Patient)	Nov 2012	5/5
McWatters, Wendie (Patient)	Nov 2012	5/5
Morgan, Henry (Public—Wandsworth 1)	Nov 2010	5/5
Nemeth, Cyril (Appointed—Westminster City Council)	Nov 2012	2/5
Smith-Gordon, Sandra (Public—Kensington & Chelsea 2)	Nov 2011	5/5
Taylor, Cllr Frances (Royal Borough of Kensington & Chelsea)	Oct 2012	5/5
Than, Maddy (Staff—Support, Admin and Clerical)	Nov 2011	5/5
While, Alison (Kings College)	Oct 2012	3/5
Worrall, Steve	Nov 2012	2/2
Youngstein, Taryn (Patient)[33]	Nov 2009	0/3
Tera Younger	Nov 2012	2/2

Access to register of governors' interests

Members of the public can gain access to the register of governors' interests by making a request to the Foundation Trust Secretary, Chelsea and Westminster Hospital NHS Foundation Trust, 369 Fulham Road, London, SW10 9NH, via email ftsecretary@chelwest.nhs.uk or on 020 8846 6716.

How the Board have acted to understand the views of governors and Foundation Trust Members

Executive and Non-executive Directors have attended Council of Governors meetings to gain an understanding of the views of governors and the membership constituencies they represent.

25 Resigned 26.04.2012
26 Resigned 31.03.2013
27 Term of office expiry 22.11.2012
28Term of office expiry 22.11.2012
29 Term of office expiry 22.11.2012
30 Brian Gazzard is the Lead Governor
31 Resigned 31.03.2013
32 Term of office expiry 22.11.2012
33 Term of office expiry 22 Nov 2012

A joint Board and the Council of Governors Away Day was held in December 2012, where the Chief Executive gave a presentation on the Trust strategy Further information on the process for involvement of governors was presented to the Council of Governors in February 2013. The draft annul plan was presented at the May Council of Governors meeting.

Council of Governors—who's who for the period April 2012–March 2013

If individuals joined or left the Council of Governors during the financial year, the number of meetings has been adjusted accordingly.

Directors' attendance at Council of Governors meetings 2012/13

Non-executive Directors	Attendance
Prof Sir Christopher Edwards	5/5
Sir John Baker	4/5
Prof Richard Kitney	3/5
Jeremy Loyd	4/5
Sir Geoff Mulcahy	5/5
Karin Norman	3/5

Executive Directors	Attendance
Tony Bell OBE	3/3
Heather Lawrence OBE[34]	1/1
Mike Anderson[35]	3/5
Lorraine Bewes	3/5
Thérèse Davis	1/5
Zoë Penn[36]	0/0
David Radbourne[37]	3/5
Catherine Mooney[38]	5/5

34 Attended Council meetings until July 2012
35 Attended Council meetings as Acting Chief Executive July—September 2012 and as Medical Director Sep 2012–Feb 2013
36 Was in post at the end of 2012/13 but no Council of Governors meetings took place during that period
37 Attends Council meetings as Interim Chief Operating Officer Apr–Dec 2012 and as Substantive Chief Operating Officer Jan–Mar 2013
38 Attends Council meetings as Company Secretary

FINANCE

Chelsea and Westminster Hospital NHS Foundation Trust - Annual Accounts Year 2012/13

STATEMENT OF ACCOUNTING OFFICER'S RESPONSIBILITY

Statement of the Chief Executive's responsibilities as the Accounting Officer of Chelsea and Westminster Hospital NHS Foundation Trust.

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

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

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

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

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

Tony Bell OBE

Chief Executive and Accounting Officer

28th May 2013

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST

We have audited the financial statements of Chelsea and Westminster Hospital NHS Foundation Trust for the year ended 31 March 2013 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Cash Flow Statement and the related notes 1 to 38. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Chelsea and Westminster Hospital NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the accounting officer and auditor

As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code of NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the trust's affairs as at 31 March 2013 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls;
- proper practices have not been observed in the compilation of the financial statements; or
- the NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts.

Heather Bygrave, FCA (Senior Statutory Auditor)
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
St Albans, United Kingdom

29 May 2013

Annual governance statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Chelsea and Westminster NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Chelsea and Westminster NHS Foundation Trust for the year ended 31 Mar 2013 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust has a risk management strategy and operational policy approved by the Trust Board. This outlines the strategic direction for the management of risk and the framework for the continued development of risk management processes. The responsibilities of the Trust Board are outlined confirming the role of the Chief Executive as the Accountable Officer. Interim arrangements were in place from July 2012 prior to the appointment of the new chief executive in September 2012 and these changes have not affected the Trust's capacity to handle risk.

The Risk Policy outlines the Trust reporting mechanisms for risks, including committee structures and individual responsibilities. The Assurance Committee and Audit Committee are the two main committees reporting to the Board for risk related matters. . Reporting committees to the Assurance Committee are the Risk Management Committee, the Trust Executive Quality Committee, the Health and Safety Committee and the Facilities Committee. All Directors working in the Trust take responsibility for risk identification, management and mitigation within their areas of work and practice, in line with the management and accountability arrangements in the Trust and as described in the policy.

Risk management training is given to staff on induction and regular training opportunities are provided within the hospital to staff at all levels, based on their responsibilities and the Trust's Training Needs Analysis eg staff taking on the role of lead investigator in a serious incident review for the first time will be given specific training.

The Trust seeks to learn from good practice and from incidents or near misses in a variety of ways including a dedicated section in the quarterly risk reports to the Risk Management Committee and the Assurance Committee on learning, Divisional quality reports, a requirement that discussion of incidents and risk assessments at relevant committees eg the Risk Management Committee and Trust Executive Quality Committee, is disseminated and risk newsletters.

The Trust is currently at level 2 of the Clinical Negligence Scheme for Trusts (CNST) maternity standards and level 2 of the general NHS Litigation Authority Risk Management Standards. Assessment against the level 2 standards for maternity is due in July 2013.

Risk and control framework

Risk management strategy and management of risk

The risk management strategy identifies the key elements to managing risk.

This includes reactive risk management through analysis of incidents, identification of trends, investigations of serious incidents and subsequently identification of action plans to reduce risk. These actions are monitored through the divisions and the Risk Management Committee.

Risk is identified in the Trust proactively in a number of different ways. Directorates and departments undertake an annual comprehensive risk review. Risk identification and management is also driven by the Health and Safety Committee who monitor that risk assessments are undertaken for dangerous substances, lone working, moving and handling and falls. Risks may also be identified from incidents, complaints and claims. The risk assessment templates support identification of mitigation and action planning.

Risks are evaluated and controlled through Divisions and corporate committees, the frequency depending on the severity of the risk and this is overseen by the central risk team. Risk appetite is determined by the Board.

Risk management is embedded in the activity of the organisation in a number of ways. Risks which may prevent the Trust from achieving its strategic objectives are identified during the development of the Trust's Assurance Framework. Risks identified through papers to the Board are reported through a quarterly risk report as part of the Board Assurance Framework.

In addition to participating in comprehensive risk reviews Directorates and departments are required to identify risks associated with the delivery of objectives and the delivery of cost improvement programmes. Risk identification is part of the business planning template; and risk identification is included in application forms for capital expenditure. The capital plan is regularly compared with the risk register to ensure significant risks requiring funding are prioritised. Risk reports for contracted out services and other areas related to estates and facilities are considered at every Facilities Committee meeting.

Quality Governance

The key elements of the quality governance arrangements are as described in Monitor's Quality Governance Framework; strategy, capabilities and culture, processes and structure and measurement. The Trust undertakes a yearly review of performance against the key elements of the quality governance framework and identifies actions to be taken. More detail is provided in the annual report and quality report.

The quality of performance information is assessed by the performance managers and by the Divisions' top teams through monthly performance reporting to Divisional Boards and to the monthly Performance and Finance Meetings chaired by the Chief Operating Officer. Performance information is also assessed at the weekly A&E meeting and at the fortnightly outpatients meeting.

Care Quality Commission

Compliance with the Care Quality Commission (CQC) registration requirements is assured by the Assurance Committee through review of the CQC standards compliance using provider compliance assessments for each standard and by regularly measuring compliance on the wards through a ward based assessment tool. Action plans are developed from these reviews and regularly reviewed. The CQC undertook a routine inspection in July 2013 and reported that the Trust was meeting all of the essential standards of quality and safety.

Data security

The Trust manages its risks to data security through a number of different approaches. The Trust has a Board level Senior Information Risk Owner (SIRO). The SIRO chairs an Information Governance Committee (IGC) which is responsible for setting the framework for information governance standards in the Trust and ensuring delivery of action plans to improve compliance.

A key part of the IGC's work is to review compliance against the Information Governance Toolkit and to ensure the evidence is assured. Based on the Trust's performance over the last few years internal audit do not consider it is necessary to audit every year. The Information Governance toolkit (Connecting for Health) assessment for 2012/13 assessed all major requirement areas at Level 3 and all requirements met the minimum Level 2.

The Audit Committee receives a regular update on information governance and assures the Board through the reports to the Board.

Organisation's major risks

Areas of uncertainty and risk in 2013/14 include continued financial pressures and the potential impact of proposed NHS reforms, both nationally and locally in North West London. This relates to the reconfiguration of A&E services and London as a whole including the provision of tertiary paediatrics, HIV and burns services.

There has been a change in the commissioning of public health services from Primary Care Trusts to Local Authorities from 1 April 2013. The method of commissioning Sexual Health and the tariff across London is uncertain and this could present a significant risk to the Trust's income in the short to medium term. In addition, this is an open access service and there are potentially clinical risks if patients are unable to obtain advice and treatment due to lack of funding agreements. The Trust is working with Local Authorities and other key stakeholders to clarify funding arrangements. The impact of the mitigating actions will be measured through reports to the Board including the financial report.

There are uncertainties around the impact of the practical implementation of the Health and Social Care Act, in particular the transfer of responsibility for commissioning services to GPs, the relaxation of the private patient income cap, more choice for patients and increased competition.

The overall Trust strategy has taken these issues into account and plans are in place to mitigate and/or benefit from these changes.

The main risks to quality improvement include the challenge of embedding the Trust values and changing staff behaviour to achieve the Trust aim to be in the top 10% of Trusts for the inpatients survey in all areas. Actions are being led and monitored by the Patient and Staff Experience Committee, overseen by the Board. Two of the Trust quality priorities link to improving the patient experience. Clinical risks include failure to recognise the deteriorating patient, and failure to achieve the Trust targets for mandatory training including local induction for temporary staff. Both of these areas have clear action plans which are monitored regularly through the Trust Committees and at Divisional level.

Patients are involved in risks which affect them through representation via the governors at the Council of Governors and through the Council of Governors Quality sub-committee. Kensington and Chelsea Local Involvement Network and the commissioners are also members of the Quality sub- committee and involved in setting priorities as described in the quality report. The commissioners are also involved in risks which affect them through negotiation on the contract. In addition there is liaison and partnership work with relevant bodies on risks which affect them or which they can mitigate eg ISS Mediclean for facilities management, Healthcare and Transport Services Limited for transport, Norland for estates, the local safeguarding children's board for children's issues and various organisations for safeguarding vulnerable adults. The Trust also works with local agencies on emergency and business continuity planning.

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

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

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

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

The development and reporting of patient level costing and service level reporting continues, to ensure that the Board is aware of relative profitability and efficiency. The Trust has continued a programme overseeing the improvement of patient level costing data quality to support the delivery of the Cost Improvement Programme.

Monthly finance and performance reports are provided to the Board. This information is used proactively to identify opportunities for improving efficiency and profitability for each service. Service line reports have been developed to improve access to drill down reports to investigate cost variation and are reported to the service on a monthly basis. The Trust has exceeded the target for generation of net surplus and has delivered its target Cost Improvement Programme.

It is within Internal Audit's remit to make recommendations on the effective use of resources and they have undertaken a review of processes for data quality management, financial management and financial reporting.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Reports for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

The Director of Governance and Corporate Affairs led the process with the support of other directors, the Head of Quality and Assurance and the key stakeholders through the Council of Governors meetings, the Council of Governors Quality Sub-Committee and executive and other meetings within the Trust. The involvement of stakeholders and how the priorities were set is described in more detail in the quality report. Ensuring that their input was sought, that the content reflected this accordingly and that it was checked by them ensures that we present a balanced view and that the data is accurate. Other assurance was obtained through our own assurance processes and internal and external audit. The quality report outlines our position on data quality in more detail. The quality metrics are reported to the Assurance Committee monthly, with an update on progress on priorities quarterly.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me, including financial reports throughout the year and internal and external assurance through audit. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and the Assurance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board ensures the effectiveness of the system of internal control through clear accountability and reporting arrangements.

The Audit Committee is a formal sub-committee of the Board and is accountable to the Board for reviewing the establishment and maintenance of an effective system of internal control and risk management. The committee meets at least 5 times per year. The Audit Committee approves the annual audit plans for internal and external audit activities and ensures that recommendations to improve weaknesses in control arising from audits are actioned by management. More information is contained in the governance section of the annual report.

The Board monitors the Assurance Framework and objectives quarterly, ensuring actions to address gaps in control and gaps in assurance are progressed.

The Finance and Investment Committee conducts an objective review of financial and investment policy issues and reports to the Board.

The Assurance Committee is a formal sub-committee of the Board. This committee is accountable for seeking assurance that systems, processes and outcomes contribute to the Trust's aims and values and objectives relating to patient safety and quality, a safe and clean hospital environment and staff satisfaction and to ensure that there is evidence of robust governance and assurance processes in these areas. The Trust Executive Quality Committee, the Risk Management Committee and the Facilities Committee report into the Assurance Committee.

Internal audit services are outsourced to KPMG. KPMG have provided an objective and independent opinion to the Chief Executive, the Board and the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisation's agreed objectives. Each assignment is discussed with the appropriate line manager or director and a report including management responses and a proposed action plan is presented to the Audit Committee. Internal Audit routinely follows up action with management to establish the level of compliance and the results are reported to the Audit Committee.

Executive directors are accountable for ensuring management arrangements are in place to develop relevant strategies, policies, systems and procedures to maintain internal control and to take action to address any gaps identified from the review of these systems. Executive directors are responsible for setting team objectives to ensure the delivery of corporate objectives and the management of risk. There is a quarterly report to the Board on progress on objectives, including a review of the risks.

There is a clinical audit strategy, a policy and a yearly plan which takes into account national and local clinical audit requirements. There is a continued focus on clinical audit to drive service improvement and patient safety.

Significant internal control issues

A serious incident in October 2011 which involved the death of a member of staff, identified a lack of control over the safe use of liquid nitrogen in the Trust. A range of measures was put in place to mitigate any future risk. Additional recommendations following a review of the incident have been implemented to strengthen arrangements for health and safety in the Trust; however, health and safety will continue to be a focus for 2013/14.

While significant improvements have been made in ensuring staff receive mandatory training, this is not yet at an acceptable level and this will be addressed in 2013/14.

The list of Never Events was extended to 25 in 2011/12 and our reporting systems identified three occurring this year. These have been thoroughly investigated and measures put in place to prevent re-occurrence. It is disappointing that they occurred and a further review of controls and assurances for all never events was initiated this year and prevention of never events will remain a high priority for 2013/14.

Conclusion

Other than the control issues specified above, of which all have been mitigated or robust plans are in place to do so, there are no other significant control issues.

Tony Bell OBE
Chief Executive
28 May 2013

Foreword to the Accounts

These accounts for the year ended 31 March 2013 have been prepared by Chelsea and Westminster Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

Tony Bell OBE
Chief Executive
28th May 2013

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2013

	NOTE	2012/13 £000	2011/12 £000
Operating Income			
Operating Income from Operations	3	**345,918**	342,805
Operating Expenses from Operations	4	**(322,134)**	(319,002)
Operating Surplus		**23,784**	23,803
Finance Costs			
Finance Income	8.1	**156**	134
Finance Expense - Financial Liabilities	8.2	**(931)**	(629)
Finance Expense - Unwinding of discount on provisions	20.3	**(19)**	0
Public Dividend Capital Dividend Payable		**(9,947)**	(9,670)
Net Finance Costs		**(10,741)**	(10,165)
Surplus for the Year		**13,043**	13,638
Other Comprehensive Income:			
Revaluation Loss on Property, Plant and Equipment		**0**	(6,234)
Total Comprehensive Income for the Year		**13,043**	7,404

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2013

	NOTE	31 Mar 13 £000	31 Mar 12 £000
Non-Current Assets:			
Intangible Assets	9	**6,245**	5,603
Property Plant and Equipment	10	**340,161**	333,973
Total Non-Current Assets		**346,406**	339,576
Current Assets:			
Inventories	12	**6,475**	6,340
Trade and Other Receivables	13	**14,197**	13,106
Cash and Cash Equivalents	21	**41,618**	40,997
Total Current Assets		**62,290**	60,443
Current Liabilities:			
Trade and Other Payables	15	**(34,692)**	(31,698)
Borrowings	17.1	**(3,827)**	(1,802)
Provisions	20.1	**(2,620)**	(6,490)
Other Liabilities	16.1	**(2,202)**	(7,058)
Total Current Liabilities		**(43,341)**	(47,048)
Total Assets Less Current Liabilities		**365,355**	352,971
Non-Current Liabilities:			
Borrowings	17.2	**(25,458)**	(26,286)
Provisions	20.2	**(710)**	(461)
Other Liabilities	16.2	**(70)**	(150)
Total Non-Current Liabilities		**(26,238)**	(26,897)
Total Assets Employed		**339,117**	326,074
Financed By (Taxpayers' Equity)			
Public Dividend Capital		**162,549**	162,549
Revaluation Reserve	23	**89,187**	89,262
Income and Expenditure Reserve		**87,381**	74,263
Total Taxpayers' equity		**339,117**	326,074

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Tony Bell OBE, Chief Executive

28th May 2013

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

For The Year Ended 31 March 2013

	Total	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' Equity at 1 April 12	**326,074**	162,549	89,262	74,263
Surplus for the year	**13,043**	0	0	13,043
Asset disposals	**0**	0	(75)	75
Taxpayers' Equity at 31 March 13	**339,117**	162,549	89,187	87,381

	Total	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' Equity at 1 April 11	**318,670**	**162,549**	**95,880**	**60,241**
Surplus for the year	**13,638**	0	0	13,638
Revaluation (loss) on property, plant and equipment	**(6,234)**	0	(6,234)	0
Asset disposals	**0**	0	(384)	384
Taxpayers' Equity at 31 March 12	**326,074**	**162,549**	**89,262**	**74,263**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2013

	NOTE	2012/13 £000	2011/12 £000
Cash Flows from Operating Activities			
Operating Surplus		**23,784**	23,803
Non-cash Income and Expense:			
Depreciation and Amortisation	4	**11,690**	10,231
(Increase) / Decrease in Trade and Other Receivables		**(1,446)**	2,901
Increase in Inventories		**(135)**	(259)
Increase / (Decrease) in Trade and Other Payables		**1,091**	(4,881)
(Decrease) / Increase in Other Liabilities		**(4,936)**	408
(Decrease) / Increase in Provisions		**(3,640)**	4,086
Other movements in Operating Cash flows		**129**	43
NET CASH GENERATED FROM OPERATIONS		**26,537**	36,332
Cash Flows from Investing Activities			
Interest Received		**156**	135
Purchase of Intangible Assets		**(2,263)**	(1,935)
Purchase of Property, Plant and Equipment		**(14,513)**	(34,305)
NET CASH USED IN INVESTING ACTIVITIES		**(16,620)**	(36,105)
Cash Flows from Financing Activities			
Loans Received		**3,200**	13,276
Loans Repaid		**(1,813)**	0
Capital Element of Finance Lease Rental Payments		**(189)**	(173)
Interest Paid		**(794)**	(422)
Interest Element of Finance Leases		**(108)**	(116)
PDC Dividends Paid		**(9,592)**	(10,568)
NET CASH (USED IN) / FROM FINANCING ACTIVITIES		**(9,296)**	1,997
Increase in Cash and Cash Equivalents		**621**	2,224
Cash and Cash Equivalents at 1 April 2012		**40,997**	38,773
Cash and Cash Equivalents at 31 March 2013		**41,618**	40,997

1. Accounting policies and other information

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2012/13 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 New and revised standards and interpretations

The following standards, amendments and interpretations have been issued by the International Accounting Standards Board (IASB) and International Financial Reporting Interpretations Committee (IFRIC) but have not yet been adopted in the Annual Reporting Manual. Monitor does not permit the early adoption of accounting standards, amendments and interpretations that are in issue at the reporting date but effective at a subsequent reporting period.

- IFRS 7 Financial Instruments: Disclosures – amendment. Offsetting financial assets and liabilities.
- IFRS 9 Financial Instruments: Financial Assets & Financial Liabilities
- IFRS 10 Consolidated Financial Statements
- IFRS 11 Joint Arrangements
- IFRS 12 Disclosure of Interests in Other Entities
- IFRS 13 Fair Value Measurement
- IAS 1 Presentation of Financial Statements, on other comprehensive income (OCI)
- IAS 19 (Revised 2011) Employee Benefits
- IAS 12 Income Taxes Amendment
- IAS 27 Separate Financial Statements
- IAS 28 Associates and Joint Ventures
- IAS 32 Financial Instruments: Presentation – amendment. Offsetting financial assets and Liabilities.

The directors do not expect that the adoption of these standards and interpretations will have a material impact on the financial statements in future periods. All other revised and new standards have not been listed here as they are not considered to have an impact on the Trust.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention, modified by the revaluation of properties, and, where material, current asset investments and inventories to fair value as determined by the relevant accounting standard.

1.3 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

In accordance with IAS 18, income relating to those spells which are partially completed at the financial year end is apportioned across the financial years on a pro rata basis.

1.4 Expenditure on Employee Benefits

1.4.1 Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.5 Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2013, is based on the valuation data as 31 March 2012, updated to 31 March 2013 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members.

The last published valuation undertaken for the NHS Pension Scheme was completed for the year ended 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions,

and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

1.6 Expenditure on other goods and services

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

1.7 Property, Plant and Equipment

1.7.1 Recognition

Property, plant and equipment is capitalised where:

• It is held for use in delivering services or for administrative purposes;

• It is probable that future economic benefits will flow to, or service potential be provided to, the Trust;

• It is expected to be used for more than one financial year;

• The cost of the item can be measured reliably;

• The item has a cost of at least £5,000; or

• collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

• items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

1.8 Measurement

1.8.1 Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Properties in the course of construction are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value.

All assets are measured subsequently at fair value as follows:

(a) Land and non-specialised buildings – market value

(b) Specialised buildings – depreciated replacement cost

(c) Non-property assets - depreciated historic cost

The carrying values of property, plant and equipment are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be fully recoverable.

All land and buildings are restated to fair value in accordance with IAS 16 and Monitor guidance, using professional valuations every five years to ensure that fair values are not materially different from the carrying amounts. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual based on modern equivalent asset values. The last valuation was carried out by Montagu Evans (Independent Chartered Surveyors, Registration number OC312072) as at 31st March 2012.

1.8.2 Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised.

1.8.3 Depreciation

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

Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Property, plant and equipment are depreciated over the following useful lives:

•Buildings are depreciated on a straight line basis, after accounting for residual value, over the remaining useful economic life of 35 to 38 years;

•Dwellings and leasehold improvements are depreciated over the shorter of the useful economic life or lease term;

•Plant and machinery, furniture and fittings and information technology are depreciated on a straight line basis over the useful economic life of the asset, deemed as 5 years for short life assets, 10 years for medium life assets and 15 years for long life assets.

•Transport equipment is depreciated on a straight line basis over 5 years.

1.8.4 Revaluation and impairment

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

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

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

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

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

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

1.9 De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

• The asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• The sale must be highly probable i.e;
(a) management are committed to a plan to sell the asset;
(b) An active programme has begun to find a buyer and complete the sale;
(c) The asset is being actively marketed at a reasonable price;
(d) The sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
(e) The actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

1.10 Donated, government grant and other grant funded assets

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

1.11 Private Finance Initiative (PFI) transactions

The Trust is not party to any PFI transactions.

1.12 Intangible assets

1.12.1 Recognition

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

1.12.2 Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

(a) the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;

(b) the Trust intends to complete the asset and sell or use it;
(c) the Trust has the ability to sell or use the asset;
(d) how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
(e) adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
(f) the Trust can measure reliably the expenses attributable to the asset during development.

Expenditure which does not meet the criteria for capitalisation is treated as an operating expense in the year in which it is incurred. Where possible, the Trust discloses the total amount of research and development expenditure charged in the Statement of Comprehensive Income separately. However, where research and development activity cannot be separated from patient care activity it cannot be identified and is therefore not separately disclosed.

1.13 Software

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

1.14 Measurement

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

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

1.15 Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Software is amortised over 3-10 years.

1.16 Revenue government and other grants

Government grants are grants from government bodies other than income from primary care trusts or NHS trusts for the provision of services. Grants from the Department of Health are accounted for as government grants. Where the government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.17 Inventories

Inventories are stated at the lower of cost and net realisable value. The cost of inventories is measured using the First In, First Out (FIFO) method.

1.18 Cash and Cash Equivalents

Cash and cash equivalents comprise of cash on hand and demand deposits and other short term highly liquid investments. These balances are readily convertible to a known amount of cash and are subject to an insignificant risk of changes in value. Monies held in the Trust's bank account belonging to patients are excluded from cash and cash equivalents (see "third party assets" below).

Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases overdrafts are disclosed within payables. Interest earned on bank accounts and interest charged on overdrafts is recorded respectively as "finance income" and "finance cost" in the periods to which it relates. Bank charges are recorded as operating expense in the periods to which they relate.

1.19 Financial instruments and financial liabilities

Financial instruments are defined as contracts that give rise to a financial asset of one entity and a financial liability or equity instrument of another entity. The Trust will commonly have the following financial assets and liabilities: trade receivables (but not prepayments), cash and cash equivalents, trade payables (but not deferred income), finance lease obligations, borrowings.

1.20 Recognition

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

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

Regular way purchases or sales are recognised and de-recognised, as applicable, using the trade date.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

1.21 De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risk and rewards of ownership.

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

1.22 Classification and Measurement

Financial assets are classified into the following specified categories:

- Financial assets 'at fair value through Income and Expenditure'; or
- 'Loans and receivables'; or
- 'Available-for-sale' financial assets.

Financial liabilities are classified as either:

- Financial liabilities 'at fair value through Income and Expenditure'; or
- 'Other financial liabilities'.

The Trust has no financial assets classified as 'at fair value through Income and Expenditure' or 'Available for sale'. There are also no financial liabilities classified as 'at fair value through income and expenditure'.

1.23 Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and 'other receivables'.

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income, except for short-term receivables when the recognition of interest would be immaterial.

1.24 Other financial liabilities

All 'other' financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the date of the Statement of Financial Position, which are classified as non-current liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

1.25 Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset. Evidence is gathered via formal communication between the Trust and the counterparties.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of bad debt provision. The bad debt provision is charged to operating expenses.

1.26 Leases

1.26.1 Finance leases

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

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

1.26.2 Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

1.26.3 Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

1.27 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's short, medium and / or long-term real discount rate(s) for the financial year.

1.28 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at note 20.3 to the accounts.

1.29 Non-clinical risk pooling

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

1.30 Contingencies

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

Contingent liabilities are not recognised but are disclosed in the notes to the accounts, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

(a) Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

(b) Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.31 Public dividend capital

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

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) net cash balances held with the Government Banking Service (GBS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.32 Value Added Tax

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

1.33 Corporation Tax

Corporation tax is not applicable to the Trust.

1.34 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

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

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:
• Monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
• Non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
• Non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

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

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

1.35 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

2 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, which are described in note 1, the directors are required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

2.1 Critical judgements in applying the group's accounting policies

The following are the critical judgements, apart from those involving estimations (which are dealt with separately below), that the directors have made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in financial statements.

Revenue recognition

The directors have determined that the recoverability of overseas patient income is critical to the recognition of income in the financial statements. In accordance with the requirements of IAS 18 Revenue, the Trust makes an assessment of the recoverability of overseas debt at the point of delivery of treatment. This is to ensure adherence to the accounting principles set out in IAS 18 that: 'Revenue is recognised only when it is probable that the economic benefits associated with the transaction will flow to the entity'. Overseas patients arise for a number of reasons, and every overseas patient in the Trust is interviewed by an Overseas Officer as soon as is reasonably practical to do so, to assess their NHS entitlement, status and ability to pay.

Disputes with Commissioners

As set out in Note 20.3, Management has made an assessment of the potential liability of the Trust from contractual disputes with commissioners. Provisions for the disputes are £0.4m at 31st March 2013 (31st March 2012 £4.4m). The disputes relate to challenges on pricing or charging that it has not been possible to settle by reference to the contract, under which the Trust has been entitled to the income. The Trust has recognised the income in relation to the disputes in its Statement of Comprehensive Income and the commissioning bodies have settled the debts. However there is precedent for the Trust agreeing a negotiated settlement with commissioners, on contractual challenges raised during the year on issues that are not sufficiently clear in the contracts. The Trust has determined the level of provision on a basis that reflects settlement of the issue for the financial year in which the issue was raised and any subsequent years but not to retrospectively settle claims.

2.2 Key sources of estimation uncertainty

The key assumptions concerning the future, and other key sources of estimation uncertainty at the statement of position date, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year, are discussed below.

Valuation of land and buildings, including life of main hospital building

In line with our policy of five – yearly valuations the Trust's main hospital building was revalued at 31st March 2012 by external independent valuers who determined that the use of a general hospital build cost index (provided by BCIS) applied to the gross internal area of the hospital was the appropriate index to be used. Management supports the use of this index, which is consistent with the index used in prior years, as opposed to changing to an alternative index. The alternative index would be a detailed list of specialist indices (provided by BCIS) applicable to the gross internal area of each part of the

building, for example, wards, theatres or laboratories. The directors are satisfied that the application of a consistently applied general index in the property valuation is more important than reflecting minor changes in valuation from change in use of areas of the hospital building through use of a department specific index, particularly when the independent valuers have advised the difference in overall valuation between the two methods would not be significant. In the current year the directors have considered whether there has been sufficient volatility in costs or asset values to require a revaluation, and whether any impairment arises on capitalisation of projects completed in the year, and have concluded that no revaluation is required.

NOTES TO THE ACCOUNTS

3 Operating Income from Operations

NOTE

3.1 Operating Income (by classification)

		2012/13	2011/12
Income from activities		***£000***	*£000*
Elective income		**44,116**	46,590
Non elective income		**69,396**	70,524
Outpatient income		**68,947**	67,660
Accident & Emergency income		**11,635**	11,061
Other NHS clinical income		**95,618**	92,232
Private patient income	3.3	**11,920**	11,264
Other non-protected clinical income		**3,279**	2,224
Total Income from Activities	3.4	**304,911**	301,555

3.2

	2012/13	2011/12
Other Operating Income:	***£000***	*£000*
Research and development	**5,406**	5,347
Education and training	**25,341**	25,901
Charitable and other contributions to expenditure and capital	**1,987**	89
Non-patient care services to other bodies	**441**	955
Other income	**7,832**	8,958
Total Other Operating Income	**41,007**	41,250
Total Operating Income from Operations	**345,918**	342,805

3.3 Private patient income (PPI):

The statutory limitation on private patient income in section 44 of the 2006 Act was repealed with effect from 1 October 2012 by the Health and Social Care Act 2012. The financial statements disclosures that were provided previously are therefore no longer required.

3.4 Operating Income (by type)

Income from activities	***£000***	*£000*
NHS Foundation Trusts	**1,509**	1,012
NHS Trusts	**150**	64
Primary Care Trusts	**289,712**	288,066
Local Authorities or other government bodies	**234**	171
Non NHS: Private patients	**10,940**	10,464
Non NHS: Overseas patients (non-reciprocal)	**980**	800
NHS injury scheme	**679**	895
Non NHS: Other	**707**	83
Total	**304,911**	301,555

NOTES TO THE ACCOUNTS

4	Operating Expenses from Operations	2012/13	2011/12
	Operating Expenses	**£000**	£000
	Staff costs	**175,910**	170,422
	Executive directors' costs	**787**	781
	Non executive directors' costs	**117**	128
	Termination benefit	**44**	16
	Early retirements	**0**	29
	Drug costs	**55,477**	52,126
	Supplies and services - clinical (excluding drug costs)	**35,730**	36,422
	Supplies and services - general	**4,247**	5,184
	Transport	**1,593**	1,595
	Research and Development	**26**	878
	Establishment	**4,221**	4,896
	Premises	**21,109**	20,914
	Services from NHS trusts and foundation trusts	**606**	797
	Purchase of healthcare from non NHS bodies	**1,814**	1,394
	Legal fees	**276**	261
	Consultancy costs	**1,900**	2,127
	Training, courses and conferences	**684**	835
	Patient travel	**123**	131
	Car parking & Security	**27**	42
	Hospitality	**93**	71
	Insurance	**172**	201
	Audit fees:		
	Audit services- statutory audit	**128**	124
	Other non-audit services	**21**	0
	Clinical negligence	**6,176**	5,623
	Decrease in bad debt provision	**(78)**	(2,683)
	(Decrease) / Increase in other provisions	**(1,120)**	4,109
	Depreciation on property, plant and equipment	**10,069**	9,029
	Amortisation on intangible assets	**1,621**	1,202
	Loss on disposal of other property, plant and equipment	**122**	20
	Other	**239**	2,328
	Total Operating Expenses from Operations	**322,134**	319,002

4.1 Operating leases

4.1.1 Arrangements containing an operating lease	2012/13	2011/12
	£000	£000
Minimum lease payments	**2,094**	1,936

4.1.2 Arrangements containing an operating lease	31 Mar 13	31 Mar 12
Future minimum lease payments due:	**£000**	£000
- not later than one year;	**1,230**	1,592
- later than one year and not later than five years;	**3,007**	3,720
- later than five years.	**2,817**	3,334
Total	**7,054**	8,646

NOTES TO THE ACCOUNTS

5 Employee expenses and numbers

5.1 Employee expenses

	2012/13 £000	2011/12 £000
Salaries and wages	**137,621**	130,067
Social security costs	**12,369**	12,083
Employers' contributions to NHS Pension Scheme	**14,913**	14,596
Termination benefit	**44**	16
Agency/contract staff	**13,733**	16,541
Costs capitalised as part of assets	**(1,939)**	(2,055)
Total	**176,741**	171,248

5.2 Average number of persons employed (WTE Basis)

	2012/13 WTE	2011/12 WTE
Medical and dental	**575**	560
Administration and estates	**603**	607
Healthcare assistants and other support staff	**306**	273
Nursing, midwifery and health visiting staff	**1,071**	1,047
Scientific, therapeutic and technical staff	**406**	373
Bank and agency staff	**456**	441
Other	**0**	0
Total	**3,417**	3,301
of which:		
Number of employees engaged on capital projects	**27**	27

(WTE - Whole Time Equivalent)

5.3 Employee benefits

	2012/13 £000	2011/12 £000
Employee benefits	40	23

5.4 Retirements due to ill-health

During 2012/13 there was one early retirement from the Trust agreed on the grounds of ill-health; the estimated additional pension liabilities of ill health retirements for the year ended 31st March 2013 were £0.03m. In 2011/12 there were two; the estimated additional pension liabilities of ill-health retirements for the year ended 31 March 2012 were £0.2m.

5.5 Exit packages

During 2012/13 there was one compulsory redundancy with banding £10,000-£25,000 and one other agreed departure with banding £25,001-£50,000. In 2011/12 there was one compulsory redundancy within banding £10,000-£25,000.

NOTES TO THE ACCOUNTS

5.6

Salary and Pension entitlements of senior managers

Name & Position	a) Remuneration						b) Pension				
	Salary for the year ended 31 Mar 13	Salary for the year ended 31 Mar 12	Performance Related Pay for the year ended 31 Mar 13	Performance Related Pay for the year ended 31 Mar 12	Total Salaries for the year ended 31 Mar 13	Total Salaries for the year ended 31 Mar 12	Accrued pension and related lump sum at age 60 as at 31 Mar 13	Real increase/ (decrease) in pension and related lump sum at age 60 as at 31 Mar 13	CETV at 31 Mar 13	CETV at 31 Mar 12	Real increase/ (decrease) in CETV for the year ended 31 Mar 13
	Bands of £5,000	Bands of £5,000	Bands of £5,000	Bands of £5,000	Bands of £5,000	Bands of £5,000	Bands of £5,000	Bands of £2,500	(£'000)	(£'000)	(£'000)
Executive Directors											
Heather Lawrence OBE, Chief Executive[1]	55-60	185 - 190	0	10-15	55-60	200-205	0	0	0	0	0
Tony Bell OBE, Chief Executive[2]	115-120	0	0	0	115-120	0	0	0	0	0	0
Dr Mike Anderson, Medical Director[3]	120-125	170-175	0	0	120-125	170-175	325.0-330.0	(15.0-12.5)	0	0	0
Zoe Penn, Medical Director[4]	5-10	0	0	0	5-10	0	135.0-140.0	0	632	0	0
Lorraine Bewes, Director of Finance	145-150	130 - 135	0	0	145-150	130 - 135	155.0-160.0	12.5-15.0	732	651	60
Amanda Pritchard, Deputy Chief Executive (Director of Integrated Service Delivery & Modernisation)[5]	0-5	120 - 125	0	0	0-5	120 - 125	100.0-105.0	12.5-15.0	317	257	52
David Radbourne, Chief Operating Officer[6]	130-135	0	0	0	130-135	0	100.0-105.0	10.0-15.0	335	271	55
Therese Davis, Chief Nurse and Director of Patient Experience and Flow	115-120	110 - 115	0	0	115-120	110 - 115	140.0-145.0	5.0-7.5	583	528	38
Non-Executive Directors											
Prof. Sir Christopher Edwards, Chairman	35-40	35-40	0	0	35-40	35-40	0	0	0	0	0
Sir John Baker CBE, Vice Chair	15-20	15-20	0	0	15-20	15-20	0	0	0	0	0
Karin Norman, Non-Executive Director	10-15	10-15	0	0	10-15	10-15	0	0	0	0	0
Prof. Richard Kitney OBE, Non-Executive Director	10-15	10-15	0	0	10-15	10-15	0	0	0	0	0
Jeremy Loyd, Non-Executive Director	10-15	10-15	0	0	10-15	10-15	0	0	0	0	0
Sir Geoffrey Mulcahy, Non-Executive Director	10-15	10-15	0	0	10-15	10-15	0	0	0	0	0

Note 5.6 cont./

Name & Position	a) Remuneration						b) Pension				
	Salary for the year ended 31 Mar 13	Salary for the year ended 31 Mar 12	Performance Related Pay for the year ended 31 Mar 13	Performance Related Pay for the year ended 31 Mar 12	Total Salaries for the year ended 31 Mar 13	Total Salaries for the year ended 31 Mar 12	Accrued pension and related lump sum at age 60 as at 31 Mar 13	Real increase/ (decrease) in pension and related lump sum at age 60 as at 31 Mar 13	CETV at 31 Mar 13	CETV at 31 Mar 12	Real increase/ (decrease) in CETV for the year ended 31 Mar 13
	Bands of £5,000	Bands of £5,000	Bands of £5,000	Bands of £5,000	Bands of £5,000	Bands of £5,000	Bands of £5,000	Bands of £2,500	(£'000)	(£'000)	(£'000)
Directors											
Mark Gammage, Director of Human Resources & Organisational Development	80-85	75-80	0	0	80-85	75-80	45.0-50.0	(2.5-0.0)	262	241	14
Catherine Mooney, Director of Governance & Corporate Affairs	90-95	85-90	0	0	90-95	85-90	125.0-130.0	5.0-7.5	606	530	59
Axel Heitmueller, Director of Strategy and Service Planning	90-95	80-85	0	0	90-95	80-85	0.0-5.0	0.0-2.5	31	16	15
Bill Gordon, Director of Information Management and Technology	95-100	80-85	0	0	95-100	80-85	0	0	0	0	0
Cynthia Conquest, Interim Deputy Director of Finance[7]	120-125	0	0	0	120-125	0	0	0	0	0	0
Carol McLaughlin, Acting Deputy Director of Finance[8]	65-70	0	0	0	65-70	0	80.0-85.0	2.5-5.0	274	244	22
Kelda Alleyne, Deputy Director of Finance[9]	15-20	85-90	0	0	15-20	85-90	0.0-5.0	0.0-2.5	49	44	4

Notes to senior managers' salary and pension table

1 Chief Executive left the Trust 23 July 2012.
2 Appointed 3 September 2012.
3 Covered the Chief Executive role between 23rd July 2012 and 3rd September 2012: and ceased to be Medical Director from 28th February 2013 but continued in role as clinical consultant.
4 Appointed 1 March 2013.
5 Left 16 April 2012.
6 Covered on secondment from City and Hackney PCT; substantively appointed on 1st Jan 2013. Cost reported for period of secondment is full cost to the Trust.
7 Interim paid via agency appointed as Interim Deputy Director of Finance 18 June 2012.
8 Acting Deputy Director of Finance since 18 June 2012.
9 Moved to new role 17 June 2012.

NOTES TO THE ACCOUNTS

5.6 continued

Non executive directors do not receive pensionable remuneration therefore there are no entries in respect of pensions for them. A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any spouse's contingent pension payable from the scheme.

A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figure shown relates to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures include the value of any pension benefits in another scheme or arrangement in which the individual has transferred to the NHS pension scheme. They also include any additional pension benefits accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

Real increase in CETV for current year may be significantly different from prior year. This is due to a change in the factors used to calculate CETVs, which came into force on 1 October 2008 as a result of the Occupational Pension Scheme (Transfer Value Amendment) regulations. These placed responsibility for the calculation method for CETVs (following actuarial advice) on Scheme Managers or Trustees. Further regulations from the Department for Work and Pensions to determine cash equivalent transfer values (CETV) from Public Sector Pension Schemes came into force on 13 October 2008.

6 Better Payment Practice Code

6.1 Better Payment Practice Code - measure of compliance

	2012/13		2011/12	
	Number	**£000**	Number	£000
Total bills paid in the year	**68,557**	**156,421**	70,830	183,460
Total bills paid within the target	**58,698**	**144,283**	65,430	176,799
Percentage of bills paid within target	**85.6%**	**92.2%**	92.4%	96.4%

The Better Payment Practice Code requires the Trust to aim to pay 95% of all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

There were no amounts included within interest expense (note 8.2) arising from claims made under this legislation (2011/12 - nil).

7 Loss on Disposal of Fixed Assets

The loss on disposal of fixed assets was £0.12m (2011/12 - £0.02m) arising from the replacement of engineering plant as a result of the infrastructure project and the disposal of modelling software.

NOTES TO THE ACCOUNTS

8 Finance

8.1 Finance Income

	2012/13	2011/12
	£000	£000
Interest on bank accounts	156	134

8.2 Finance Expense - Financial Liabilities

	2012/13	2011/12
	£000	£000
Loans from the Foundation Trust Financing Facility	831	516
Finance leases	100	113
	931	629

9 Intangible assets

9.1 Software Licences/ Information Technology

	31 Mar 13	31 Mar 12
	£000	£000
Cost or valuation at 1 April	8,035	6,100
Additions	2,263	1,935
Cost or valuation at 31 March	10,298	8,035
Amortisation at 1 April	2,432	1,230
Provided during the year	1,621	1,202
Amortisation at 31 March	4,053	2,432
Opening Net book value		
Owned	5,603	4,870
Opening Net Book Value Total	5,603	4,870
Closing Net book value		
Owned	6,245	5,603
Closing Net Book Value Total	6,245	5,603

NOTES TO THE ACCOUNTS

10 Property, plant and equipment

10.1 Property, plant & equipment at the balance sheet date 31 March 2013 : -

	Note	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
		£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 12		50,000	249,338	2,001	8,939	36,050	121	12,711	1,089	360,249
Additions - purchased		0	0	0	13,497	1,587	0	0	88	15,172
Additions - donated	26.1	0	147	0	1,000	68	0	0	0	1,215
Reclassifications		0	15,939	0	(18,014)	641	0	1,328	106	0
Disposals		0	(61)	0	(40)	(1,687)	0	(418)	0	(2,206)
Cost or valuation at 31 March 13		**50,000**	**265,363**	**2,001**	**5,382**	**36,659**	**121**	**13,621**	**1,283**	**374,430**
Accumulated depreciation at 1 April 12		0	634	0	0	18,759	48	6,699	136	26,276
Provided during the year		0	3,743	125	0	3,789	24	2,213	175	10,069
Disposal		0	(10)	0	0	(1,648)	0	(418)	0	(2,076)
Accumulated Depreciation at 31 March 13		**0**	**4,367**	**125**	**0**	**20,900**	**72**	**8,494**	**311**	**34,269**
Net book value										
Owned at 31 March 13		50,000	254,955	0	5,382	15,146	0	5,103	972	331,558
Finance lease at 31 March 13		0	0	1,876	0	118	0	0	0	1,994
Donated at 31 March 13		0	6,041	0	0	495	49	24	0	6,609
NBV Total at 31 March 13		**50,000**	**260,996**	**1,876**	**5,382**	**15,759**	**49**	**5,127**	**972**	**340,161**
Protected assets at 31 March 13		50,000	258,810	1,876	0	0	0	0	0	310,686
Unprotected assets at 31 March 13		0	2,186	0	5,382	15,759	49	5,127	972	29,475
Total at 31 March 13		**50,000**	**260,996**	**1,876**	**5,382**	**15,759**	**49**	**5,127**	**972**	**340,161**
Net book value										
Owned at 31 March 12		50,000	242,778	0	8,939	16,529	0	5,982	953	325,181
Finance lease at 31 March 12		0	0	2,001	0	235	0	0	0	2,236
Donated at 31 March 12		0	5,926	0	0	527	73	30	0	6,556
Total at 31 March 12		**50,000**	**248,704**	**2,001**	**8,939**	**17,291**	**73**	**6,012**	**953**	**333,973**
Net book value										
Protected assets at 31 March 12		50,000	246,147	2,001	0	0	0	0	0	298,148
Unprotected assets at 31 March 12		0	2,557	0	8,939	17,291	73	6,012	953	35,825
		50,000	**248,704**	**2,001**	**8,939**	**17,291**	**73**	**6,012**	**953**	**333,973**

NOTES TO THE ACCOUNTS

10 Property, plant and equipment (cont.)

10.2 Property, plant & equipment at the balance sheet date 31 March 2012 : -

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 11	50,000	225,896	2,001	15,927	39,523	121	11,123	427	345,018
Additions - purchased	0	0	0	27,818	1,716	0	0	662	30,196
Additions - donated	0	654	0	0	34	0	30	0	718
Reclassifications	0	32,058	0	(34,806)	1,190	0	1,558	0	0
Other revaluations	0	(9,247)	0	0	0	0	0	0	(9,247)
Disposals	0	(23)	0	0	(6,413)	0	0	0	(6,436)
Cost or valuation at 31 March 12	**50,000**	**249,338**	**2,001**	**8,939**	**36,050**	**121**	**12,711**	**1,089**	**360,249**
Accumulated depreciation at 1 April 11	0	241	111	0	21,506	24	4,746	48	26,676
Provided during the year	0	3,187	111	0	3,666	24	1,953	88	9,029
Revaluation surplus	0	(2,791)	(222)	0	0	0	0	0	(3,013)
Disposal	0	(3)	0	0	(6,413)	0	0	0	(6,416)
Accumulated Depreciation at 31 March 12	**0**	**634**	**0**	**0**	**18,759**	**48**	**6,699**	**136**	**26,276**
Net book value									
Owned at 31 March 12	50,000	242,778	0	8,939	16,529	0	5,982	953	325,181
Finance lease at 31 March 12	0	0	2,001	0	235	0	0	0	2,236
Donated at 31 March 12	0	5,926	0	0	527	73	30	0	6,556
NBV Total at 31 March 12	**50,000**	**248,704**	**2,001**	**8,939**	**17,291**	**73**	**6,012**	**953**	**333,973**
Protected assets at 31 March 12	50,000	246,147	2,001	0	0	0	0	0	298,148
Unprotected assets at 31 March 12	0	2,557	0	8,939	17,291	73	6,012	953	35,825
Total at 31 March 12	**50,000**	**248,704**	**2,001**	**8,939**	**17,291**	**73**	**6,012**	**953**	**333,973**
Net book value									
Owned at 31 March 11	50,000	220,450	0	15,927	17,056	1	6,377	379	310,190
Finance lease at 31 March 11	0	0	1,890	0	353	0	0	0	2,243
Donated at 31 March 11	0	5,205	0	0	608	96	0	0	5,909
Total at 31 March 11	**50,000**	**225,655**	**1,890**	**15,927**	**18,017**	**97**	**6,377**	**379**	**318,342**
Net book value									
Protected assets at 31 March 11	50,000	222,715	1,890	0	0	0	0	0	274,605
Unprotected assets at 31 March 11	0	2,940	0	15,927	18,017	97	6,377	379	43,737
Total at 31 March 11	**50,000**	**225,655**	**1,890**	**15,927**	**18,017**	**97**	**6,377**	**379**	**318,342**

NOTES TO THE ACCOUNTS

11 Net book value of assets held under finance lease contracts at the Statement of Position date:

11.1 Finance Lease Assets

	31 Mar 13 £000	31 Mar 12 £000
Dwellings	**1,876**	2,001
Plant and Machinery	**118**	235

11.2 The total amount of depreciation charged to the Statement of Comprehensive Income in respect of assets held under finance lease:

	2012/13 £000	2011/12 £000
Dwellings	**125**	111
Plant and Machinery	**118**	118

Contingent rents charged to the Statement of Comprehensive Income in the period are not material.

12 Inventory

12.1 Inventories

	31 Mar 13 £000	31 Mar 12 £000
Raw materials and consumables	**6,475**	6,340

12.2 Inventories recognised in expenses

	2012/13 £000	2011/12 £000
Inventories recognised in expenses	**55,442**	39,740
Write-down of inventories as expense	**44**	0
	55,486	39,740

The disclosure above reflects consumables tracked as stock through the year, which are primarily drugs. The increase on 2011/12 reflects changes in stock management processes. The expense for other consumables included within inventories at year-end is shown in note 4 as part of Clinical Supplies and Services expenditure.

13 Trade receivables and other receivables

13.1 Current Receivables

		31 Mar 13 £000	31 Mar 12 £000
NHS Receivables		**7,528**	7,431
Provision for impaired receivables	14.1	**(3,919)**	(4,497)
Prepayments		**1,489**	1,495
Accrued income		**1,247**	835
PDC Dividend		**99**	454
Other receivables		**7,753**	7,388
Total current trade and other receivables		**14,197**	13,106

14 Impairment of receivables

14.1 Provision for impairment of receivables

	31 Mar 13 £000	31 Mar 12 £000
At 1 April	**4,497**	7,938
Increase in provision	**2,498**	3,139
Amounts utilised	**(500)**	(758)
Unused amounts reversed	**(2,576)**	(5,822)
At 31 March	**3,919**	4,497

14.2 Analysis of Impaired Receivables

	31 Mar 13 £000	31 Mar 12 £000
Ageing of impaired receivables		
Up to three months	**1,102**	1,975
In three to six months	**621**	105
Over six months	**2,196**	2,417
Total	**3,919**	4,497
Ageing of non-impaired receivables past their due date		
Up to three months	**1,163**	726
In three to six months	**0**	359
Over six months	**0**	18
Total	**1,163**	1,103

NOTES TO THE ACCOUNTS

15 Trade and other payables

15.1 Current Payables

	31 Mar 13 £000	31 Mar 12 £000
NHS payables	**3,742**	3,813
Trade payables - capital	**3,171**	1,297
Trade payable - other related parties	**2,136**	2,321
Other trade payables	**5,404**	5,312
Other payables	**8,322**	7,030
Accruals	**11,917**	11,925
Total Current Payables	**34,692**	31,698

16 Other Liabilities

16.1 Current

	31 Mar 13 £000	31 Mar 12 £000
Deferred income	**2,100**	5,558
Deferred Government grant	**102**	1,500
Total Other Current Liabilities	**2,202**	7,058

16.2 Non-Current

	31 Mar 13 £000	31 Mar 12 £000
Deferred Government grant	**70**	150
Total Other Non-Current liabilities	**70**	150

17 Borrowings

17.1 Current Borrowings

	31 Mar 13 £000	31 Mar 12 £000
Loans from Foundation Trust Financing Facility	**3,625**	1,613
Obligations under finance leases	**202**	189
Total Current Borrowings	**3,827**	1,802

17.2 Non-current Borrowings

	31 Mar 13 £000	31 Mar 12 £000
Loans from Foundation Trust Financing Facility	**23,563**	24,188
Obligations under finance leases	**1,895**	2,098
Total Non-Current Borrowings	**25,458**	26,286

The loan from the Foundation Trust Financing Facility is repayable over 10 years and the interest rate is 3.06%.

18 Finance Lease

18.1 Finance Lease Obligations

	31 Mar 13 £000	31 Mar 12 £000
Gross Lease Liabilities	**2,749**	3,025
of which liabilities are due:		
- not later than one year;	**279**	275
- later than one year and not later than five years	**605**	727
- later than five years	**1,865**	2,023
	2,749	3,025
Less: finance charges allocated to future periods	**(652)**	(738)
Net Lease Liabilities	**2,097**	2,287
of which liabilities are due:		
- not later than one year;	**202**	189
- later than one year and not later than five years	**357**	459
- later than five years	**1,538**	1,639

18.2 Finance Lease Commitments

	31 Mar 13 £000	31 Mar 12 £000
Minimum payments	**2,749**	3,025
Number of years of commitment	**15**	16

NOTES TO THE ACCOUNTS

19 Prudential Borrowing Limit (PBL)

	31 Mar 13 £000 Authorised	31 Mar 13 £000 Actual	31 Mar 12 £000 Authorised	31 Mar 12 £000 Actual
Total long term borrowing	**59,100**	**29,286**	55,300	28,088
Working capital facility	**20,000**	**0**	20,000	0
Total	**79,100**	**29,286**	75,300	28,088

Disclosure of the actual working capital facility as at 31 March 2013 and 31 March 2012 is the amount drawn down.

Financial Ratios		**31 Mar 13**		31 Mar 12	
	Prudential Borrowing Limits	**Approved PBL Ratio**	**Actual PBL Ratio**	Approved PBL Ratio	Actual PBL Ratio
Minimum dividend cover (times)	**>1.0x**	3.5x	3.5x	2.9x	3.5x
Minimum interest cover (times)	**>3.0x**	36.6x	38.4x	43.1x	54.3x
Minimum debt service cover (times)	**>2.0x**	30.8x	31.9x	34.7x	42.6x
Maximum debt service to revenue (%)	**<3.0%**	0.3%	0.3%	0.3%	0.2%

The Trust is required to comply and remain within a Prudential Borrowing Limit. This is made up of two elements:
- the maximum cumulative amount of long term borrowing. This is set by reference to the four ratio tests set out in the Prudential Borrowing Code for NHS foundation trusts. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit, and
- the amount of any working capital facility approved by Monitor.

Further information on the *Prudential Borrowing Code for NHS foundation trusts* and *Compliance Framework* can be found on Monitor's website.

20 Provisions for Liabilities and Charges

20.1 Current Provisions

	31 Mar 13 £000	31 Mar 12 £000
Pensions relating to other staff	**44**	13
Other provisions including short term employee benefit	**2,576**	6,477
Total Current Provisions	**2,620**	6,490

20.2 Non-current Provisions

	31 Mar 13 £000	31 Mar 12 £000
Pensions relating to other staff	**634**	385
Other provisions including short term employee benefit	**76**	76
Total Non-current Provisions	**710**	461

20.3 Provisions for liabilities and charges analysis

	Pensions - Other Staff	**Others including Employee benefit**	**Contractual Disputes**	**Total Provision**
	£000	£000	£000	£000
At 1 April 2012	398	2,133	4,420	6,951
Arising during the year	305	237	411	953
Utilised during the year	(44)	(100)	(2,373)	(2,517)
Reversed unused	0	(29)	(2,047)	(2,076)
Unwinding of discount	19	0	0	19
At 31 March 2013	678	2,241	411	3,330
Expected timing of cash flows:				
Not later than one year;	44	2,165	411	2,620
Later than one year and not later than five years;	177	76	0	253
Later than five years.	457	0	0	457
	678	**2,241**	**411**	**3,330**

The contractual disputes provision relates to disputes with NHS North West London on NHS Clinical Contract Income. They relate to challenges on pricing and/or charging disputes for 2012-13 activity. The basis for these figures is contractual disputes raised by NHS North West London.

Clinical Negligence Liabilities

The amount included in provisions of the National Health Service Litigation Authority at 31 March 2013 in respect of clinical negligence of the Trust is £66m (2011/12 - £58.9m)

NOTES TO THE ACCOUNTS

21 Cash and cash equivalents

	31 Mar 13	31 Mar 12
	£000	£000
Balance at 1 April	**40,997**	38,773
Net change in year	**621**	2,224
Balance at 31 March	**41,618**	40,997
Comprising:		
Cash at commercial banks and in hand	**8**	59
Cash with the Government Banking Service	**41,610**	40,938
Cash and cash equivalents as in Statement of Cash Flows	**41,618**	40,997

22 Third Party Assets

The Trust held £0.03m cash at bank at 31 March 2013 (2011/12 - £0.02m) which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

23 Revaluation Reserve

	31 Mar 13	31 Mar 12
	£000	£000
Revaluation reserve at 1 April	**89,262**	95,880
Revaluation losses and impairment losses on property, plant and equipment	**0**	(6,234)
Asset disposals	**(75)**	(384)
Revaluation reserve at 31 March	**89,187**	89,262

24 Contractual Capital Commitments

Commitments under capital expenditure contracts at 31 March 2013 were £9.0m (2011/12 - £0.9m).

25 Events after the reporting period

There have been no events after the reporting period since the Statement of Position date.

26 Contingencies

26.1 Contingent Assets

The Trust is anticipating the receipt of £1m of donated funds from the Children's Hospital Trust Fund. The funds are a donation for the purchase of a surgical systems robot for use in paediatric surgery. The robot is within assets under construction as at 31st March and the funds to pay for the robot are due to be received from the charity in the first quarter of 2013/14.

26.2 Contingent Liabilities

There were no contingent liabilities at the Statement of Position date.

27 Related Party Transactions

27.1 Related Party Relationships

Chelsea and Westminster Hospital NHS Foundation Trust is a public benefit corporation established by the order of the Secretary of State for Health.

Government departments and their agencies are considered by HM Treasury as being related parties.

No funds are held in trust by Chelsea and Westminster Hospital NHS Foundation Trust on behalf of the Chelsea and Westminster Health Charity, but are held by the Trustees who prepare the Charity's accounts independently of the Trust.

There were related party transactions between the Trust and related companies during the year as follows:
- HR consultancy services were provided by Dearden Consulting Ltd and Dearden Search and Selection Ltd to the Trust during the year. Mark Gammage, Director of Human Resources and Organisational Development, is Managing Director of Dearden Consulting Ltd. Dearden Consulting Ltd holds a minority shareholding in Dearden Search and Selection Ltd. Transactions totalled £3k with Dearden Consulting Ltd (2011/12 £24k) and £21k with Dearden Search and Selection Ltd (2011/12 £28k) out of which £5k was still outstanding at 31st March 2013.

- Specialist procurement services were provided by Linea Group Ltd during the year. Ian Chambers, Chief Executive of Linea Group Ltd was the Director of Procurement for the Trust until June 2012. Transactions total £63k from April - June 2012 for services of Ian Chambers, provision of specialist procurement services and management and provision of contract tendering services (2011/12 £1.0m).

There was a related party transaction between the Trust and David Radbourne, Chief Operating Officer, for provision of a season ticket loan of £3k at 31st March 2013. The season ticket loan was offered as part of a Trust wide scheme open to all employees.

NOTES TO THE ACCOUNTS

27.2 Related Party Transactions	31 Mar 13 Income £000	31 Mar 12 Income £000	31 Mar 13 Expenditure £000	31 Mar 12 Expenditure £000
Croydon PCT	67,620	66,176	0	124
Kensington and Chelsea PCT	56,972	58,981	0	29
Hammersmith and Fulham PCT	38,604	38,188	11	91
Wandsworth PCT	30,747	29,460	144	291
Westminster PCT	25,424	25,547	155	61
NHS London	23,035	23,046	30	0
Ealing PCT	9,145	9,175	40	54
Hounslow PCT	7,638	7,111	9	0
Lambeth PCT	4,872	4,625	0	0
Richmond and Twickenham PCT	4,567	4,616	0	0
Brent PCT	4,129	4,631	0	164
South East Essex PCT	3,974	3,951	0	0
Department of Health	3,365	4,390	831	516
Hampshire PCT	3,346	4,412	0	44
Surrey PCT	3,242	2,966	0	65
Hillingdon PCT	2,131	1,890	0	0
Imperial College Healthcare NHS Trust	2,326	3,295	15,012	16,185
Other Government Departments and central bodies:				
HM Revenue & Customs	0	0	45,450	44,390
NHS Pensions Agency	0	0	24,714	22,398
NHS Business Services Authority	0	0	6,057	6,533
NHS Litigation Authority	0	0	6,054	5,757

27.3 Related Party Balances	31 Mar 13 Accounts Receivable £000	31 Mar 12 Accounts Receivable £000	31 Mar 13 Accounts Payable £000	31 Mar 12 Accounts Payable £000
Kensington and Chelsea PCT	970	528	0	19
Imperial College Healthcare NHS Trust	852	205	1,292	966
Ealing PCT	710	282	22	26
Hammersmith and Fulham PCT	469	34	0	139
Hounslow PCT	410	421	0	3
Croydon PCT	399	822	12	69
Wandsworth PCT	272	906	105	282
Hillingdon PCT	128	166	0	0
Richmond and Twickenham PCT	115	67	0	3
Lambeth PCT	107	0	0	43
South East Essex PCT	77	0	0	32
Surrey PCT	50	169	0	0
Westminster PCT	55	474	119	40
Hampshire PCT	54	291	0	0
NHS London	53	225	26	26
Brent PCT	48	235	0	18
Department of Health	44	0	0	0
Other Government departments and central bodies:				
HM Revenue & Customs	1,265	605	3,880	3,763
NHS Pensions Agency	0	0	2,133	1,931

The Trust has related party balances and transactions with the Department of Health for dividend payments for public dividend capital. The transactions are shown in the Statement of Comprehensive Income and the receivables balance is disclosed in note 13.1.

28 PFI Schemes

The Trust is not party to any PFI Schemes.

29 Losses and Special Payments

There were 421 cases of losses and special payments (2011/2012 - 906 cases) totalling £0.5m (2011/2012 - £1m) for the year ended 31 March 2013. The amounts reported as losses and special payments are reported on an accruals basis but excluding provisions for future losses.

NOTES TO THE ACCOUNTS

30 Financial Instruments

IAS 32 (Financial Instruments: Disclosure and Presentation), IAS 39 (Financial Instrument Recognition and Measurement) and IFRS 7 (Financial Instruments: Disclosures) require disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The Trust does not have any complex financial instruments and does not hold or issue financial instruments for speculative trading purposes. Because of the continuing service provider relationship the Trust has with primary care trusts and the way those primary care trusts are financed, the Trust is not exposed to the degree of financial risk faced by non NHS business entities.

The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Finance and Investment Committee manages the Trust's funding requirements and financial risks in line with the Board approved treasury policies and procedures and their delegated authorities.

The Trust's financial instruments comprise loans, finance lease obligations, provisions, cash at bank and in hand and various items, such as trade debtors and trade creditors, that arise directly from its operations. The main purpose of these financial instruments is to raise finance for the Trust's operations.

31 Categories of Financial Instruments

31.1 Financial assets	**31 Mar 13 £000**	31 Mar 12 £000
Loans and receivables (including cash)	**54,227**	52,153
Total	**54,227**	52,153

31.2 Financial liabilities	**31 Mar 13 £000**	31 Mar 12 £000
Other financial liabilities (amortised cost)	**63,393**	62,869
Total	**63,393**	62,869

32 Financial Instruments Book Value to Fair Values

32.1 Book Values of Financial Assets & Liabilities

	Book value 31 Mar 13 £000	Book value 31 Mar 12 £000
Financial assets	**54,227**	52,153
Financial liabilities		
Finance leases obligation for more than 1 year	**1,895**	2,098
Loans due in more than 1 year	**23,563**	24,188
Total	**25,458**	26,286

32.2 Fair Values of Financial Assets & Liabilities

	Fair value 31 Mar 13 £000	Fair value 31 Mar 12 £000
Financial liabilities		
Finance leases obligation for more than 1 year	**1,895**	2,098
Loans due in more than 1 year	**23,563**	24,188
Total	**25,458**	26,286

As allowed by IFRS 7, short term trade debtors and payables measured at amortised cost may be excluded from the above disclosure as their book values reasonably approximate their fair values.

NOTES TO THE ACCOUNTS

33 Liquidity and Interest Risk Tables

33.1 Financial assets:	Weighted ave. interest rate	Less than 1 year	1-2 years	2-5 years	More than 5 years	Total
	%	£000	£000	£000	£000	£000
Non-interest bearing		12,609	0	0	0	12,609
Variable interest rate instrument	0.45%	41,618	0	0	0	41,618
Gross financial assets at 31 March 13		**54,227**	**0**	**0**	**0**	**54,227**
Non-interest bearing		11,157	0	0	0	11,157
Variable interest rate instrument	0.45%	40,996	0	0	0	40,996
Gross financial assets at 31 March 12		**52,153**	**0**	**0**	**0**	**52,153**

33.2 Financial liabilities:	Weighted ave. interest rate	Less than 1 year	1-2 years	2-5 years	More than 5 years	Total
	%	£000	£000	£000	£000	£000
Non-interest bearing		30,854	0	0	0	30,854
Finance lease liability	3.84%	299	394	552	852	2,097
Fixed interest rate instrument	3.06%	3,625	3,625	10,875	9,063	27,188
Provisions under contract	0.33%	2,620	44	133	457	3,254
Gross financial liabilities at 31 March 13		**37,398**	**4,063**	**11,560**	**10,372**	**63,393**
Non-interest bearing		27,935	0	0	0	27,935
Finance lease liability	3.84%	286	381	667	953	2,287
Fixed interest rate instrument	3.06%	1,613	3,225	9,675	11,288	25,801
Provisions under contract	0.33%	6,448	13	39	346	6,846
Gross financial liabilities at 31 March 12		**36,282**	**3,619**	**10,381**	**12,587**	**62,869**

34 Interest Rate Risk

100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. Chelsea and Westminster Hospital NHS Foundation Trust was not, therefore, exposed to significant interest rate risk.

35 Liquidity risk

The Trust's net operating costs are mainly incurred under legally binding contracts with primary care trusts, which are financed from resources voted annually by Parliament. This provides a reliable source of funding stream which significantly reduces the Trust's exposure to liquidity risk.

The Trust also manages liquidity risk by maintaining banking facilities and loan facilities to meet its short and long term capital requirements through continuous monitoring of forecast and actual cash flows.

In addition to internally generated resources the Trust finances its capital programme through a loan facility, while the working capital is backed by a committed facility of £20m, unutilised at 31 March 2013. Details are included in note 19.

NOTES TO THE ACCOUNTS

36 Credit risk

Credit risk exists where the Trust can suffer financial loss through default of contractual obligations by a customer or counterparty.

Trade debtors consist of high value transactions with primary care trusts under contractual terms that require settlement of obligation within a time frame established generally by the Department of Health. Other trade debtors include private and overseas patients, spread across diverse geographical areas. Credit evaluation is performed on the financial condition of accounts receivable and, where appropriate, sufficient prepayment is required to mitigate the risk of financial loss.

Credit risk exposures of monetary financial assets are managed through the Trust's treasury policy which limits the value that can be placed with each approved counterparty to minimise the risk of loss. The counterparties are limited to the approved financial institutions with high credit ratings. Limits are reviewed regularly by senior management.

The maximum exposure of the Trust to credit risk is equal to the total trade and other receivables within Note 13.

37 Operating Segments

The Board of Directors is of the opinion that the Trust's operating activities fall under the single heading of healthcare for the purpose of operating segments disclosure. IFRS 8 requirements were considered and the Trust has determined that the Chief Operating Decision Maker is the Trust Board of Chelsea and Westminster Hospital NHS Foundation Trust. It is the responsibility of the Trust Board to formulate financial strategy and approve budgets. Significant operating segments that are reported internally are the ones that are required to be disclosed in the financial statements. There is no segmental reporting for revenue, assets or liabilities to the Trust Board. Expenditure is reported by segment to the Trust Board. However those segments fully satisfy the aggregation criteria to be one reportable segment as per IFRS 8. Therefore all activities of the Trust are considered to be one segment, 'Healthcare', and there are no individual reportable segments on which to make disclosures.

38 Academic Health Science Partnership

The Trust has established Imperial College Health Partners Limited, a company limited by guarantee, in the year, with Imperial College and a number of other local trusts. The company will provide central services for the Imperial Academic Health Science Partnership, in which the Trust participates. The Trust's initial investment was £1, and the Trust's contribution to the costs of the company for the year was £0.05m.

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Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 18 July 2013

AGENDA ITEM NO.	2.3/Jul/13
PAPER	External audit report on the Financial Statement audit for the year ended 31 March 2013
AUTHOR	Heather Bygrave, Deloitte LLP
LEAD	Heather Bygrave, Deloitte LLP
EXECUTIVE SUMMARY	Deloitte has completed the Financial Statement audit for the year ended 31 March 2013, issuing a “clean” unmodified opinion on the financial statements. The paper summarises the principal areas of audit focus and overall audit approach.
DECISION/ ACTION	The Council is asked to note this report

Deloitte.

Chelsea and Westminster Hospital NHS Foundation Trust

External audit report to the Council of Governors on the Financial Statement audit for the year ended 31 March 2013

9 July 2013

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The Council of Governors
Chelsea and Westminster Hospital NHS Foundation Trust
369 Fulham Road
London
SW10 9NH

9 July 2013

Dear Sirs

We have pleasure in setting out in this document our report to the Council of Governors of Chelsea and Westminster Hospital NHS Foundation Trust on our audit of the year ended 31 March 2013 financial statements. This report covers the principal matters that have arisen from our audit.

In summary:

- We have issued a “clean” unmodified opinion on the truth and fairness of the financial statements.
- We have not identified any issues to “report by exception” in respect of the Trust’s Annual Governance Statement, or the Trust’s arrangements for securing economy, efficiency and effectiveness in its use of resources.
- Our audit findings did not identify any significant deficiencies in the financial reporting systems. We have identified a number of control recommendations, which we have reported to the Audit Committee.

We would like to take this opportunity to thank Lorraine Bewes and her team for their assistance and co-operation during the course of our audit work.

Heather Bygrave
Audit Partner

Contents

We would like to take this opportunity to thank the management team for their assistance and co-operation during the course of our audit work

Executive summary

Introduction

This is a report summarising the findings of our audit of the Trust's financial statements for the year ended 31 March 2013.

We also performed procedures on the Trust's Quality Report for the same period. Our findings from that work are set out in the accompanying report.

We have issued a "clean" unmodified opinion on the Trust's financial statements.

We provided detailed reports, on both our audit of the Trust's financial statements and our work on the Trust's Quality report, to the Trust's Audit Committee on 23 May 2013.

We signed our audit opinion on the Trust's financial statements on 29 May 2013, together with the accompanying reports we are required to make to Monitor and to the National Audit Office.

Our opinion on the financial statements was as follows:

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2013 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Executive summary

Our audit report includes a clean ‘report by exception’

As well as providing an opinion on the Trust’s financial statements, Monitor’s Code of Audit Practice (“the Code”) requires us to ‘report by exception’ on certain other matters. We have not identified any issues to “report by exception” through our audit.

We included the following statement in our audit report on the Trust’s financial statements:

We have **nothing** to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls;
- proper practices have not been observed in the compilation of the financial statements; or
- the NHS Foundation Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Our approach

Procedures for auditing the Trust's financial statements

In summary, the audit of the Trust's financial statements included:

Developing an understanding of the Trust, including its systems, processes, risks, challenges and opportunities and then using this understanding to focus audit procedures on areas where we consider there to be a higher risk of misstatement in the Trust's financial statements.

Working effectively with Internal Audit to draw upon their findings as part of our risk assessment and to avoid duplication of work.

Interviewing members of the Trust's management team and reviewing documentation to test the design and implementation of the Trust's internal controls in certain key areas relevant to the financial statements.•

Performing sample tests on balances in the Trust's financial statements to supporting documentary evidence, as well as other analytical procedures, to test the validity, accuracy and completeness of those balances.

We have included further details of our audit approach in Appendix 1.

The focus of our work

Our audit approach is focused on areas of the financial statements where there is a higher risk of misstatement

- Our audit approach is designed to address the risks of material misstatement we identified for the Trust. We focused our work in areas where we considered there to be a higher risk of material misstatement. We refer to these areas as “significant audit risks”.
- We provided a detailed audit plan to the Trust’s Audit Committee in October 2012 setting out our provisional assessment of the significant audit risks for the Trust, together with our planned approach to addressing those risks. We performed detailed planning procedures in December 2012 and February 2013 and reconfirmed to the Audit Committee that we had not identified any additional significant risks from this work.
- We have provided a summary of each of the significant audit risks in the table below.
- Based on our audit work on these significant audit risks and on other transactions, balances and disclosures in the financial statements, we concluded that the Trust’s financial statements were not materially misstated.

Significant audit risk	Description of risk
Recognition of NHS income	The majority of Trust operating income is recognised under the Payment by Results (PbR) framework whereby each patient episode has a set fee to be charged to the relevant commissioning body. Information obtained from the PbR data flow forms the basis on which the Trust charges commissioners for healthcare services performed. The PbR systems and processes are typically complex with both automated and manual controls, with the final income figures agreed with commissioners on the basis of actual performance. The timetable for agreeing income for the final quarter of the year is later than the accounts deadline, and so the income for over or underperformance against plan must be estimated.

The focus of our work

Significant audit risk	Description of risk
Recognition of NHS income (continued)	At 31 March 2013, the Trust's financial statements showed that it was owed £7.5m by other NHS bodies (before provisions). Typically, Trusts do not expect to receive the full amount of debt they are owed and therefore estimate a provision against that debt in the financial statements. This was made more complex by the changes in the NHS organisational structure on 1 April 2013, as the Primary Care Trusts which owed the Trust for activity in 2012/13 were dissolved. The Trust provided for £1.3m of bad debt against NHS receivables and £0.4m for repayment of queried and disputed charges at year-end. These estimates are based on management judgements and assumptions. As auditors we focus our attention on estimates like this because, due to their nature, they are more susceptible to management bias. We concluded that NHS income and debtors were not materially misstated.
Recognition of grant revenue	In 2012/13, the Trust recognised £5.4m of research income, £25.3m of education and training income, and £1.9m of donations and contributions to capital expenditure as part of other operating income. Accounting for grant income can be complex as the timing for recognising income in the accounts will depend on the scheme rules for each grant. This has been identified as a risk area due to the material value of income, the complexity of grant contracts, and the level of judgement required to determine whether grant conditions have been met. We concluded that grant income was not materially misstated.

The focus of our work

Significant audit risk	Description of risk
Property valuation	Trusts are required to revalue land and property assets when there is evidence of significant movements in asset values, and the NHS Foundation Trust Annual Reporting Manual ("ARM") suggests that this should be at least every five years with more frequent revaluations in rapidly changing property markets. The Trust has not revalued its land and property assets at 31 March 2013 as management has concluded that the carrying value is materially in line with the fair value. The last formal valuation was performed at 31 March 2012 by a third party valuer, Montagu Evans LLP. We identified this as a risk area, as valuations are by their nature estimates driven by the assumptions used, and can change significantly with changes in the economic environment and property markets. We concluded that the Trust's property values were not materially misstated.
Management override of controls	International Standards on Auditing require us to have a presumed significant risk in relation to management override of controls. Our audit procedures to address this risk included tests of journals and consideration of estimates and judgements in the financial statements. We did not identify any significant issues in respect of our procedures.

- Other issues we considered in our audit this year included:
  - Accounting for the donation of the surgical "robot" by the Children's Hospital Trust Fund;
  - Agreement of 2013-14 contracts with commissioners;
  - "Shaping a Healthier Future" and potential West Middlesex NHS Trust transactions and the disclosures included in the Annual Report in respect of these developments; and
  - IT implementations.

  We did not identify any significant issues in respect of these areas.

The focus of our work

Other findings from our audit of the accounts

- During the course of the audit, we proposed a number of adjustments to improve the disclosure in the Annual Report and Accounts.
- We recommended a number of changes to the Annual Report and Accounts, the more significant of which were addressed by management.
- The changes made principally related to the discussion of risks in the Governance Statement, and new disclosures required by the Health and Social Care Act 2012.
- The Audit Committee concluded that those adjustments that were not corrected in the final version of the financial statements were not material in the context of the financial statements as a whole.
- We have made a number of recommendations for the improvement of the Trust's policies, procedures and internal controls through the year, which we have reported to the Audit Committee. We did not identify any recommendations that we consider to be a high priority.

Adding value

Our audit approach is designed to add value through the audit process

We consider that we have added value to our service throughout the year by:

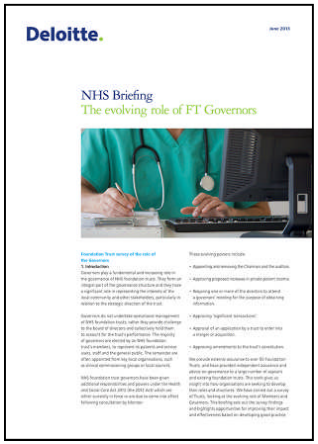
- using our property valuation and computer audit specialists in the audit process to address risks and identify recommendations;
- providing the Trust with insight on emerging issues, drawing on our insights from Heather Bygrave's representation on Monitor's Technical Issues Forum. Key issues highlighted included:
  - the potential impact of Monitor's proposed Risk Assessment Framework on the Trust's regulatory ratings;
  - new accounting requirements from changes to the Annual Reporting Manual; and
  - insight into the recent guidance on Quality Governance, which we developed for Monitor;
- providing the Trust with our NHS Briefings on topical issues affecting Foundation Trusts and the wider NHS, mostly recently on the role of Governors as discussed further below on page 11;
- benchmarking the Trust against other Foundation Trusts in terms of:
  - the contents of the Quality Report
  - the Trust's delivery of its cost improvement programme and performance on Monitor's financial metrics;
  - the Trust's performance in recovering NHS debts; and
  - the Trust's remuneration disclosures;

  Extracts from our analysis showing performance against Monitor's financial metrics are set out on page 12;
- inviting Trust representatives to our regular sector briefing events; and
- identifying control recommendations.

Adding value

NHS Briefing: The evolving role of FT governors

We have recently surveyed all Foundation Trusts to take their views on the roles and responsibilities of Governors and Members, and how these were evolving, with responses from around 45% of trusts. We have included the detailed findings in our recent NHS Briefing, copies of which have been provided to the Trust. The Briefing also includes a number of questions Trusts should consider to assess the role their Governors and Members play and how to maximise the benefits from their contribution.



Key findings include:

- only 13% of respondents considered the Members' contribution to be strong: just over 40% considered it weak or very weak;
- more than half of trusts felt their Governors made a strong or very strong contribution, with only 13% regarding the contribution as weak;
- while 52% of trusts had undertaken a skills or experience assessment of their Governors, the rate of training in various core areas was below 20%; and
- perceptions of performance differed significantly across the activities that Governors undertake. The tables below show the areas where a significant percentage of responses rated the contribution of Governors as "Good"/"Very Good" or as "Poor"/"Very Poor".

Areas of strength	% of Good/ Very good responses
Annual performance appraisal of the Chair	71.4%
Appointing a deputy chair	59.2%
Providing a governor perspective on trust performance	50.0%
Partnership working between the board and governors to enable governors to view NEDs at work	53.5%
Developing the membership strategy, ensuring representation and engagement	52.9%

Areas for development	% of Poor/ Very poor responses
Working with hospital volunteers	51.8%
Holding constituency meetings to communicate with members and understand members' views	50.0%
Giving talks to interested stakeholders	42.9%
Working with other representative bodies	32.2%
Governors attend the audit committee during the auditor selection process	28.0%
Patient and service user liaison regarding patient experience	21.4%

The results suggest there is an opportunity to use targeted training to actively improve Governors' contribution, particularly around quality governance and wider patient and stakeholder engagement.

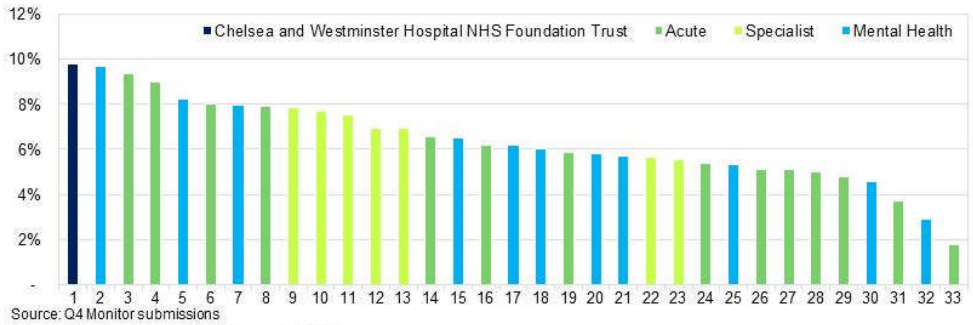
Adding value

Financial benchmarking

Our Audit Committee reports included analysis of the Trust's performance compared to other Foundation Trusts, with commentary on issues that the committee should consider. The charts below show the Trust's relative performance in its year-end Financial Risk Rating ("FRR") and on key metrics that Monitor uses to determine the FRR. The indicators shown are:

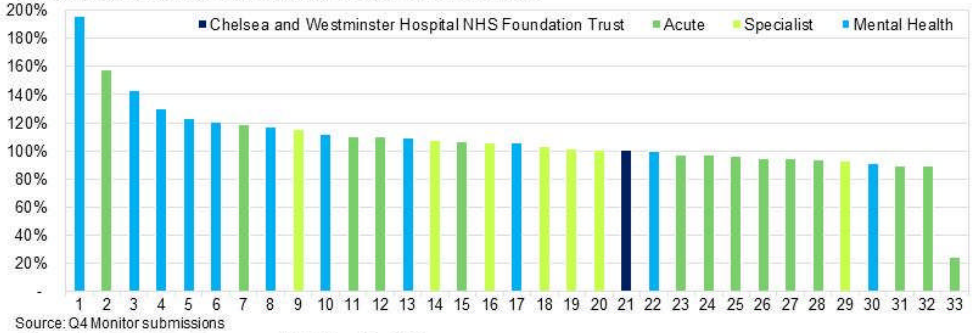
- Earnings before Interest, Tax, Depreciation and Amortisation ("EBITDA") as a percentage of income (a "profit margin" measure);
- the EBIDTA achieved as a percentage of plan (as per the Trust's Annual Plan);
- liquidity days (calculated by comparing the Trust's cash and working capital to its operating expenditure for the year).

EBITDA margin for the year ended 31 March 2013



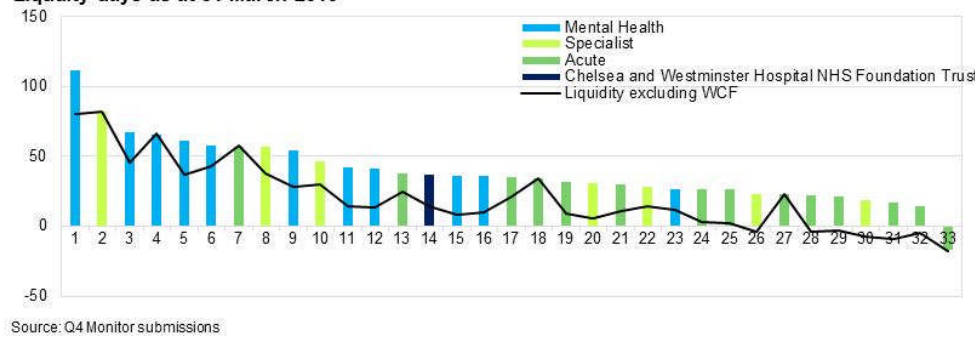
Source: Q4 Monitor submissions

EBITDA as % of plan for the year ended 31 March 2013



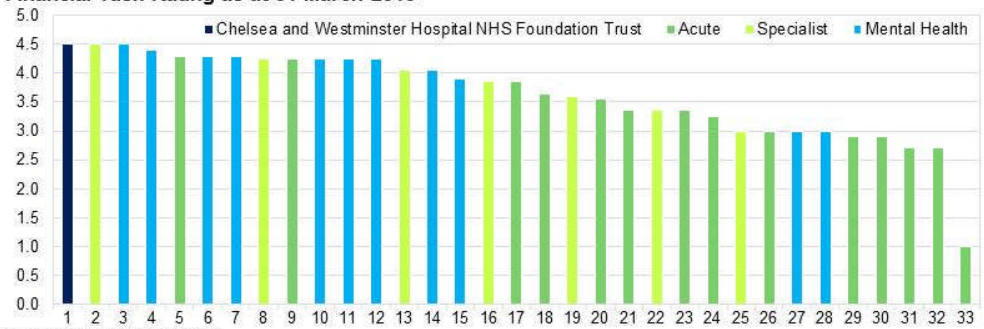
Source: Q4 Monitor submissions

Liqudity days as at 31 March 2013



Source: Q4 Monitor submissions

Financial Risk Rating as at 31 March 2013



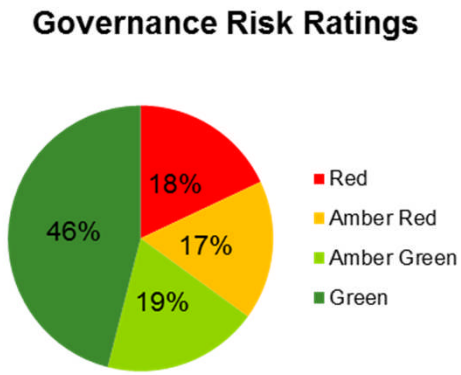
Source: Q4 Monitor submissions

The Trust's FRR of 4.5 (giving a published score of 5) compares to a national average for acute trusts of 3.1 at 31 March 2013. For acute trusts, the average FRR of Trusts with a turnover of between £200m and £400m was 3.0. This reflects the Trust's continued strong financial performance, and is overall in line with the year ended 31 March 2012.

Adding value

Governance indicators benchmarking

- The Trust's Governance Risk Rating at 31 March 2013 was Green. The chart shows the ratings across the sector at 31 March.
- The Trust met all governance indicator targets at 31 March 2013. Of the Trusts we audit, 45% of all trusts and 64% of acute trusts missed a target, with an average of 1.9 indicators missed.
- Commonly missed targets for acute trusts in Q4 were:
  - 35% of acute trusts missed the A&E 4h wait target for Q4, reflecting the significant pressure upon services at present. This compares to the average across all acute trusts nationally of 40% in breach at Q3 and 58% at Q4. The Trust met the A&E target in both quarters.
  - The increasingly stringent C.Dif. targets are reflected in breaches at 32% of trusts. The Trust had 14 C.Dif. cases compared to a target of 31. By contrast, only one trust breached the MRSA target (and four trusts nationally) – this is likely to reflect the differences in the rules for identifying breaches and the limits of the infection control strategies available.



Source: Monitor Q4 Review

Q4	% of acute trusts where targets not met	Issue at the Trust
A&E: maximum waiting time of 4 hours	35%	Achieved
Clostridium Difficile.	32%	Achieved
Cancer 62 Day Waits (urgent GP referral)	16%	Achieved
Cancer 62 Day Waits (NHS cancer screening referral)	13%	Achieved
Maximum time of 18 weeks RTT, admitted patients	14%	Achieved

Analysis of audit fees

The professional fees earned by Deloitte in the period from 1 April 2012 to 31 March 2013 are set out in the table below. Non-audit services were subject to pre-approval by the Audit Committee Chair, and the details and safeguards were reported to and considered by the Audit Committee.

	Current year £000	Prior year £000
Statutory audit of the financial statements (including work required by the National Audit Office)	87	87
Procedures in respect of quality accounts	20	19
Total audit fees	**107**	**106**
Deloitte Real Estate services in respect of Doughty House	21	-
Information technology services – Accounts Payable data analytics	6	-
Total non-audit fees	**27**	**-**
Total fees	**134**	**106**

Responsibility statement

This report should be read in conjunction with the "Briefing on audit matters" included in Appendix 1 of this report. This report sets out matters of interest which came to our attention during the audit. Our audit was not designed to identify all matters that may be relevant to the Trust and this report is not necessarily a comprehensive statement of all deficiencies which may exist in internal control or of all improvements which may be made.

This report has been prepared for the Governing Body and we therefore accept responsibility to you alone for its contents. We accept no duty, responsibility or liability to any other parties, since this report has not been prepared, and is not intended, for any other purpose. Except where required by law or regulation, it should not be made available to any other parties without our prior written consent.

Deloitte LLP

Chartered Accountants

St Albans Office

9 July 2013

Appendices

Appendix 1: Briefing on audit matters

Published for those charged with governance

This document is intended to assist those charged with governance to understand the major aspects of our audit approach, including explaining the key concepts behind the Deloitte Audit methodology including audit objectives and materiality.

Further, it describes the safeguards developed by Deloitte to counter threats to our independence and objectivity.

This document will only be reissued if significant changes to any of those matters highlighted above occur.

We will usually communicate our audit planning information and the findings from the audit separately. Where we issue separate reports these should be read in conjunction with this "Briefing on audit matters".

Approach and scope of the audit

Primary audit objectives

We conduct our audit in accordance with International Standards on Auditing (UK & Ireland) as adopted by the UK Auditing Practices Board ("APB"). Our statutory audit objectives are:

- to express an opinion in true and fair view terms to the members on the financial statements;
- to express an opinion as to whether the accounts have been properly prepared in accordance with the relevant Financial Reporting Manual;
- for certain disclosures relating to directors' remuneration to form an opinion as to whether they are made in accordance with the relevant Financial Reporting Manual; and
- to express an opinion as to whether the directors' report, including the business review, is consistent with the financial statements.

Appendix 1: Briefing on audit matters

Approach and scope of the audit (continued)

Other reporting objectives	Our reporting objectives are to: • present significant reporting findings to those charged with governance. This will highlight key judgements, important accounting policies and estimates and the application of new reporting requirements, as well as significant control observations; and • provide timely and constructive letters of recommendation to management. This will include key business process improvements and significant controls weaknesses identified during our audit.
Materiality	"Information is material if its omission or misstatement could influence the economic decisions of users taken on the basis of the financial statements. Materiality depends on the size of the item or error judged in the particular circumstances of its omission or misstatement. Thus, materiality provides a threshold or cut-off point rather than being a primary qualitative characteristic which information must have if it is to be useful." We determine materiality based on professional judgment in the context of our knowledge of the audited entity, including consideration of factors such as shareholder expectations, industry developments, financial stability and reporting requirements for the financial statements. We determine materiality to: • determine the nature, timing and extent of audit procedures; and • evaluate the effect of misstatements. The extent of our procedures is not based on materiality alone but also the quality of systems and controls in preventing material misstatement in the financial statements, and the level at which known and likely misstatements are tolerated by you in the preparation of the financial statements.

Appendix 1: Briefing on audit matters

Approach and scope of the audit (continued)

Uncorrected misstatements	In accordance with International Standards on Auditing (UK and Ireland) ("ISAs (UK and Ireland)") we will communicate to you all uncorrected misstatements (including disclosure deficiencies) identified during our audit, other than those which we believe are clearly trivial. ISAs (UK and Ireland) do not place numeric limits on the meaning of 'clearly trivial'. The Audit Engagement Partner, management and those charged with governance will agree an appropriate limit for 'clearly trivial'. In our report we will report all individual identified uncorrected misstatements in excess of this limit and other identified errors in aggregate. We will consider identified misstatements in qualitative as well as quantitative terms.
Audit methodology	Our audit methodology takes into account the changing requirements of auditing standards and adopts a risk based approach. We utilise technology in an efficient way to provide maximum value to members and create value for management and the Board whilst minimising a "box ticking" approach. Our audit methodology is designed to give directors and members the confidence that they deserve. For controls considered to be 'relevant to the audit' we evaluate the design of the controls and determine whether they have been implemented ("D & I"). The controls that are determined to be relevant to the audit will include those: • where we plan to obtain assurance through the testing of operating effectiveness; • relating to identified risks (including the risk of fraud in revenue recognition, unless rebutted and the risk of management override of controls); • where we consider we are unable to obtain sufficient audit assurance through substantive procedures alone; and • to enable us to identify and assess the risks of material misstatement of the financial statements and design and perform further audit procedures.

Appendix 1: Briefing on audit matters

Approach and scope of the audit (continued)

Other requirements of International Standards on Auditing (UK and Ireland)

ISAs (UK and Ireland) require we communicate the following additional matters:

ISA (UK & Ireland)	Matter
ISQC 1	Quality control for firms that perform audits and review of financial statements, and other assurance and related services engagements
240	The auditor's responsibilities to consider fraud in an audit of financial statements
250	Consideration of laws and regulations in an audit of financial statements
265	Communicating deficiencies in internal control to those charged with governance and management
450	Evaluation of misstatements identified during the audit
505	External confirmations
510	Initial audit engagements – opening balances
550	Related parties
560	Subsequent events
570	Going concern
600	Special considerations – audits of group financial statements (including the work of component auditors)
705	Modifications to the opinion in the independent auditor's report
706	Emphasis of matter paragraphs and other matter paragraphs in the independent auditor's report
710	Comparative information – corresponding figures and comparative financial statements
720	Section A: The auditor's responsibilities related to other information in documents containing audited financial statements

Appendix 1: Briefing on audit matters

Independence policies and procedures

Important safeguards and procedures have been developed by Deloitte to counter threats or perceived threats to our objectivity, which include the items set out below.

Safeguards and procedures

- Every opinion (not just statutory audit opinions) issued by Deloitte is subject to technical review by a member of our independent Professional Standards Review unit.
- Where appropriate, review and challenge takes place of key decisions by the Second Partner and by the Independent Review Partner, which goes beyond ISAs (UK and Ireland), and ensures the objectivity of our judgement is maintained.
- We report annually to those charged with governance our assessment of objectivity and independence. This report includes a summary of non-audit services provided together with fees receivable.
- There is formal consideration and review of the appropriateness of continuing the audit engagement before accepting reappointment.
- Periodic rotation takes place of the audit engagement partner, the independent review partner and key partners involved in the audit in accordance with our policies and professional and regulatory requirements.
- In accordance with the Revised Ethical Standards issued by the APB, there is an assessment of the level of threat to objectivity and potential safeguards to combat these threats prior to acceptance of any non-audit engagement. This would include particular focus on threats arising from self-interest, self-review, management, advocacy, over-familiarity and intimidation.
- The Firm's policies and procedures are subject to external monitoring by both the Audit Inspection Unit (AIU), which is a division of POB, and the ICAEW's Quality Assurance Directorate (QAD).

Appendix 1: Briefing on audit matters

Independence policies and procedures (continued)

Safeguards and procedures (continued)	• In the UK, statutory oversight and regulation of auditors is carried out by the Professional Oversight Board (POB) which is an operating body of the Financial Reporting Council. The Firm's policies and procedures are subject to external monitoring by both the Audit Inspection Unit (AIU), which is a division of POB, and the ICAEW's Quality Assurance Department (QAD). The AIU is charged with monitoring the quality of audits of economically significant entities and the QAD with monitoring statutory compliance of audits for all other entities. Both report to the ICAEW's Audit Registration Committee. The AIU also reports to POB and can inform the Financial Reporting Review Panel of concerns it has with the accounts of individual companies.
Independence policies	Our detailed ethical policies' standards and independence policies are issued to all partners and employees who are required to confirm their compliance annually. We are also required to comply with the policies of other relevant professional and regulatory bodies. Amongst other things, these policies: • state that no Deloitte partner (or any closely-related person) is allowed to hold a financial interest in any of our UK audited entities; • require that professional staff may not work on assignments if they (or any closely-related person) have a financial interest in the audited entity or a party to the transaction or if they have a beneficial interest in a trust holding a financial position in the audited entity; • state that no person in a position to influence the conduct and outcome of the audit (or any closely related persons) should enter into business relationships with UK audited entities or their affiliates; • prohibit any professional employee from obtaining gifts from audited entities unless the value is clearly insignificant; and • provide safeguards against potential conflicts of interest.

Appendix 1: Briefing on audit matters

Independence policies and procedures (continued)

Remuneration and evaluation policies	Partners are evaluated on roles and responsibilities they take within the firm including their technical ability and their ability to manage risk.
APB Revised Ethical Standards	The Auditing Practices Board (APB) has issued five ethical standards for auditors that apply a 'threats' and 'safeguards' approach. The five standards cover: • maintaining integrity, objectivity and independence; • financial, business, employment and personal relationships between auditors and their audited entities; • long association of audit partners and other audit team members with audit engagements; • audit fees, remuneration and evaluation of the audit team, litigation between auditors and their audited entities, and gifts and hospitality received from audited entities; and • non-audit services provided to audited entities. Our policies and procedures comply with these standards.

Deloitte LLP is a limited liability partnership registered in England and Wales with registered number OC303675 and its registered office at 2 New Street Square, London EC4A 3BZ, United Kingdom. Tel: +44 (0) 20 7936 3000 Fax: +44 (0) 20 7583 1198.

Member of Deloitte Touche Tohmatsu Limited

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 18 July 2013

AGENDA ITEM NO.	2.4/Jul/13
PAPER	Findings and recommendations from the 2012/13 NHS Quality Report External Assurance Review
AUTHOR	Heather Bygrave, Deloitte LLP
LEAD	Heather Bygrave, Deloitte LLP
EXECUTIVE SUMMARY	Deloitte has completed the external assurance review on the Quality Report for the year ended 31 March 2013. The report summarises the principal findings and recommendations from the review, the scope of which covered: • whether the content of the report met regulatory requirements; • whether the contents were consistent with other information on the Trust's performance; and • data testing for three performance indicators – C.Difficile, 62 day cancer waits, and Incidents resulting in severe harm or death.
DECISION/ ACTION	The Council is asked to note this report

Annex 2

Auditor's Limited Assurance Report

Independent Auditor's Report to the Council of Governors of Chelsea and Westminster Hospital NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Chelsea and Westminster Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Chelsea and Westminster Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2013 (the "Quality Report") and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of Chelsea and Westminster Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting Chelsea and Westminster Hospital NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2013, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Chelsea and Westminster Hospital NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- *Clostridium Difficile*;
- Maximum 62 day waiting time from urgent GP referral to treatment for all cancers.

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

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

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

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

- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports.*

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

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the documents specified within the detailed guidance. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). Our responsibilities do not extend to any other information.

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

Assurance work performed

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

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.
- Making enquiries of management.
- Testing key management controls.
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report.
- Reading the documents.

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

Limitations

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

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

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Chelsea and Westminster Hospital NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual;*
- the Quality Report is not consistent in all material respects with the sources specified in the guidance; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual.*

Deloitte LLP
Chartered Accountants
St Albans
29 May 2013

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 18 July 2013

AGENDA ITEM NO.	2.5/Jul/13
PAPER	Audit Committee Annual Report 2012/13
AUTHOR	Lorraine Bewes, Director of Finance
LEAD	Sir Geoff Mulcahy, Non-executive Director
EXECUTIVE SUMMARY	This draft paper outlines key Audit Committee activity for the financial year 2012/13 and provides evidence for the assurances that have been made to the Board with regard to the Trust's risk management, internal control and governance processes being adequate and effective. The report summarises the external assurance received during the year from internal audit, external audit and the local counter fraud specialist. The opinion of the Committee is that the Trust's risk management, control and governance processes are adequate and effective and may be relied upon by the Board. However the Audit Committee wishes to draw to the Board's attention that the Assurance Committee has highlighted that it is not assured with respect to some of its top concerns, namely mandatory training (attendance, assurance), health and safety (culture, ownership, attendance), clinical indicators including department level performance, patient experience (improved consistency of satisfaction), values (embedding at all levels), staff appraisals (effective, meaningful and regular) and performance management processes for staff (ensure effective part of behaviour change and overall culture shift).The Audit Committee has recommended that an audit to assure on the overall arrangements and plans for clinical audit be included in the 2013/14 plan.
DECISION/ ACTION	For information.

CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST

Draft Audit Committee Annual Report for financial year 2012/13

1.0 Introduction

1.1 The Committee's chief function is to advise the Board on the adequacy and effectiveness of the Trust's systems of internal control and its arrangements for risk management, control and governance processes, and securing economy, efficiency and effectiveness (value for money).

1.2 In order to discharge this function the Audit Committee has prepared an annual report for the Board and Accounting Officer. This report includes information provided by Internal Audit, External Audit and other Assurance Providers, including the Assurance Committee. This report covers the financial year to 31st March 2013.

2.0 Audit Committee's Opinion

2.1 Members of the Board should recognise that assurance given can never be absolute. The highest level of assurance that can be provided to the Board is a reasonable assurance that there are no major weaknesses in the Trust's risk management, control and governance processes.

2.2 The opinion of the Committee, based on the issues set out in section 3 below, is that the Trust's risk management, control and governance processes are adequate and effective and may be relied upon by the Board.

3.0 Information supporting Opinion

3.1 Summarised below is the key information / sources of assurance that the Committee has relied upon when formulating our opinion.

3.2 Internal Audit

3.2.1 2012-13 represents the second full year of internal audit service provision by KPMG, following the appointment on 1 December 2010. KPMG has Provided a substantial assurance Head of Internal Audit opinion for 2012-13 on the overall adequacy and effectiveness of the Trust's risk management, control and governance processes for the year ended 31 March 2013.

3.2.2 KPMG's opinion is that:

Substantial assurance can be given that there is a generally sound system of internal control on key financial and management processes. These are designed to meet the Trust's objectives, and controls are generally being applied consistently.'

No high risk recommendations were raised by KPMG in 2012-13.

3.2.3 KPMG has delivered 10 reviews. Of these, an 'adequate assurance' opinion was provided for financial management, financial reporting, safeguarding, statutory and mandatory training, research governance and working with

CCGs. Four 'requires improvement' opinions were provided for reviews on plans for revalidation of doctors, patient experience, estates strategy and data quality management.

Within each review, areas of best practice have been highlighted by KPMG toenhance the current arrangements that are in place.

3.2.4 For the year to 31 March 2013, the Head of Internal Audit considered that there were no issues that needed to be brought to the attention of Trust Management that they considered relevant to the Governance Statement.

3.3 External Audit

3.3.1 Deloitte LLP has continued to serve as external auditors.

3.3.2 The external auditors will be reporting to the Audit Committee on 21st May 2013 on the accounts prepared for the year to 31st March 2013. It is anticipated that they will be issuing an unqualified audit opinion. The accounts will be approved at the Board on 28th May and will be signed to ensure they are delivered to Monitor within the required timescale (30th May).

Use of Resources: External audit are required to review the Trust's use of resources and to be satisfied that proper arrangements have been made for securing economy, efficiency and effectiveness in the use of resources. It is anticipated that their review will identify no matters that needed to be referred to in their audit report.

3.3.3 The Audit Committee will review the Quality Accounts on 21st May and Consider how assurance over the data quality of the 2012/13 Quality Report is given to the Board when they adopt the accounts for submission on 28th May.

External audit will provide a Limited Assurance opinion on the Quality Accounts and sample testing of two indicators (C Diff and 62 day cancer waits) in the Annual Report, and a private report to the Board of Governors (with a copy given to Monitor) on a new mandated indicator, incidents resulting in severe harm or death. There are a number of changes to the required content of the Quality Accounts for 2012/13 to include indicators from the NHS Outcomes Framework.

3.3.4 The agreed metrics for External Audit are achievement of the audit within the planned audit days, submission of reports in line with internal deadlines, and submission of reports in line with Monitor deadlines. For the 2011/12 audit:

- There was an agreed overrun of £3,000.
- All 2011/12 reporting was received in line with the deadlines set.

3.4 Other Committees

3.4.1 The Trust had two other assurance committees during the year. These arethe Assurance Committee and the Finance and Investment Committee (FIC).

3.4.2 The Assurance Committee assures the Board on systems, processes and outcomes relating to quality (patient safety, effectiveness and patient experience), staff satisfaction and the environment including compliance with the Care Quality Commission Standards. In addition to the minutes being

available to the Board from the Assurance Committee there is a monthly report which identifies key issues discussed and an assessment of assurance.

3.4.4 The FIC assures the Trust Board on financial and investment policy issues, including oversight of capital investment business cases and contract awards.

3.4.5 All these committee minutes are made available to the Audit Committee. The Audit Committee noted that the Assurance Committee is not assured on 7 of their top concerns, namely:

- mandatory training (attendance, assurance),
- health and safety (culture, ownership, attendance),
- clinical indicators including department level performance,
- patient experience (improved consistency of satisfaction),
- values (embedding at all levels),
- staff appraisals (effective, meaningful and regular) and
- performance management processes for staff (ensure effective part of behaviour change and overall culture shift).

3.5 Local Counter Fraud Service (LCFS)

3.5.1 Each NHS body is required to take necessary steps to counter fraud under instructions from the Secretary of State's Directions. As a Foundation Trust, this is one our contractual requirements with PCTs. The Trust has complied with these Directions by agreeing an Annual Service Level Agreement with Parkhill for the delivery of the Local Counter Fraud Service for 2012/13, which includes a proactive counter fraud programme to detect fraud as well as investigations in response to alleged frauds. The Audit Committee receives a regular report on progress against the agreed work plan and annual report.

3.5.2 NHS Protect, who were previously known as the Counter Fraud and Security management Service (CFSMS), suspended the annual Qualitative Assessment of counter fraud provision within the NHS at the end of the 2010/11 financial year. This assessment measured the strengths and weaknesses of Local Counter Fraud arrangements within NHS bodies and bands NHS bodies into one of four rating levels. The ratings achievable are designated 1 – 4, 4 being the highest. The Trust scored a level 3 in 2010/11 (and also scored a level 3 in 2009/10 and 2008/09). A level 3 rating means that the 'organisation is performing well' and is defined within the Qualitative Assessment document as:

'To achieve a level 3 performance and assess the health body as performing well, the arrangements at level 2 should be embedded and operating effectively with clear outcomes. In addition to achieve level 3 assurances for work completed must clearly be evident and must clearly demonstrate qualitative outputs.'

NHS Protect has been conducting a pilot scheme at a number of Trusts across the UK during 2012/13 and the replacement assessment scheme is expected to be introduced at the end of 2013/14

3.5.3 Counter fraud arrangements are compliant with the Secretary of State's Directions.

4.0 The Role and Operation of the Audit Committee

4.1 Membership of the Committee

4.1.1 The members of the Committee during the period of the Report were as follows:

Sir John Baker (Chair)
Prof Richard Kitney
Sir Geoff Mulcahy

In addition the Chief Executive, Director of Finance, External Auditors, Internal Auditors, Local Counterfraud Specialist and Director of Governance and Corporate Affairs are in attendance.

4.1.2 The members of the Committee disclosed their interests, which included the following, in the Trust's register of interests:

Sir John Baker
- Director of Renewable Energy Holdings plc
- Director of Motac Holdings Ltd
- Chairman, Mayor of London's Fund for Young Musicians

Prof Richard Kitney
- Director of RJK Consultants Ltd
- Chairman and Director of Visbion Ltd

Sir Geoff Mulcahy
- Chairman, Javelin Group
- Non-executive Director, Sunderland ARC
- Trustee, Consumer Credit Counselling Service and FCC

4.1.3 The Committee was supported by Paulina Crawford.

4.2 Operation of the Committee

4.2.1 Meetings and attendance

The Committee is required to meet quarterly in line with the terms of reference. Meetings took place during the period and were attended as follows:

	23rd May 2012	**06th July 2012**	**18th Oct 2012**	**31st Jan 2013**	**TOTALS**	
					No of meetings	**%**
Sir John Baker	*P**	*P**	*P**	*P*	*4/4*	*100%*
Prof Richard Kitney	*P**	*A*	*A*	*P*	*2/4*	*50%*
Sir Geoff Mulcahy	*P**	*P**	*P**	*A*	*3/4*	*75%*
TOTAL	*100%*	*66%*	*66%*	*66%*	*9/12*	*75%*

Key – P (Present for meeting) A (Absent from meeting) N/A (Not applicable)

* In attendance

The quorum for meetings of the Committee was 66%. As the table above shows all meetings of the Committee during the period were quorate.

4.2.2 Committee Self Assessment

The Committee undertook a self assessment as to its performance using the template recommended in the Audit Committee handbook 2011 in October 2012. No material deficiencies were found.

4.2.3 Performance Indicators

The Committee has established performance indicators for External Audit, Local Counter Fraud Service and Internal Audit.

We consider there are no issues about their performance that affects their ability to support this Committee in discharging its duties.

5.0 Governance and risk management

5.1 The following information regarding Governance was presented and discussed at the Audit Committee meetings during the year:

5.2 Risk Management

5.2.1 The Trust's system of risk management including adequacy of the risk identification, recording, reporting and monitoring arrangements is outlined in the Annual Governance Statement. The Governance Statement is to be approved at the meeting of 28th May.

5.3 Governance

The Audit Committee received an annual report on Information Governance in March 2013. The Audit Committee noted the management process for providing evidence to the IG Toolkit and the adequate (green) assurance. The Committee endorsed the Toolkit submission of 95% rating.

It was noted that the Trust has achieved Level 2 and above in all Requirements which is satisfactory and compliant.

This is an improvement on last year, where one requirement, 505 achieved a level 1.

The component that was non-compliant related to the results of an internal data quality/clinical coding audit carried out in April 2011 as part of a programme of internal Information Governance audits designed to supplement the annual external Data Assurance Framework clinical coding audit.

NHS Connecting for Health sets the following percentage accuracy scores as targets;

	Level 2	Level 3
Primary Diagnosis	>=90%	>=95%
Secondary Diagnosis	>=80%	>=90%
Primary Procedure	>=90%	>=95%
Secondary Procedure	>=80%	>=90%

In 2012/13 the Trust achieved the following accuracy scores and the Trust's overall percentage of correct coding achieved compared with last year is documented in the table below.

	Correct% 2012	Correct% 2013
Primary Diagnosis	76	97.5
Secondary Diagnosis	79	97
Primary Procedure	82	98
Secondary Procedure	87	97.7

The Trust's achievement has therefore moved from level 1 to 3 in 2012/13.

6.**0** Conclusions

6.1. The opinion of the Committee is that the Trust's risk management, control and governance processes are adequate and effective and may be relied upon by the Board. However the Audit Committee wishes to draw to the Board's attention that the Assurance Committee has highlighted that it is not assured with respect to some of its top concerns, namely

- mandatory training (attendance, assurance),
- health and safety (culture, ownership, attendance),
- clinical indicators including department level performance,
- patient experience (improved consistency of satisfaction),
- values (embedding at all levels),
- staff appraisals (effective, meaningful and regular) and
- performance management processes for staff (ensure effective part of behaviour change and overall culture shift).

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 18 July 2013

AGENDA ITEM NO.	2.6/Jul/13
PAPER	*Membership Engagement and Communications calendar of events
AUTHOR	Katie Drummond-Dunn, Communications Manager
LEAD	Tony Pritchard, Acting Chief Nurse
EXECUTIVE SUMMARY	This is the programme of membership engagement and communications activity following the approval of funding at the Council of Governors meeting on 14 February 2013.
DECISION/ ACTION	The Membership Sub-Committee is invited to note this update and provide their feedback on the proposed activity.

Membership Engagement & Communications Calendar of Events 2013/14

Date/Month	Event/Activity	Lead	Cost/Funding source
April 2013			
Friday 5 April	Members' News Issue 1	Communications Manager	£210 (Council of Governors)
w/c Mon 18 Apr	Membership mailing for all public and patient members (including covering letter from Chairman, Trust News and A5 flyers about future events for members)	Communications Manager	£10,000 (Foundation Trust budget) - funding already budgeted for in Trust budget as part of our membership 'offer' of 2 mailings/year
May 2013			
Fri 3 May	Members' News Issue 2	Head of Communications	£210 (Council of Governors)
Sat 11 May	Open Day	Communications Manager	£20,000 (Council of Governors)
Monday 20 May	Medicine for Members seminar – Pain Management	Communications Manager	£700 (Council of Governors)
June 2013			
Friday 7 June	Members' News Issue 3	Head of Communications	£210 (Council of Governors)
July 2013			
Friday 28 June	Members' News Issue 4 – brought forward to promote the elections	Head of Communications	£210 (Council of Governors)
TBC	Medicine for Members seminar – Falls with Nick Hale and Natasha Booton	Communications Manager	£700 (Council of Governors)
August 2013			
Fri 2 Aug	Members' News Issue 5	Head of Communications	£210 (Council of Governors)

Date/Month	Event/Activity	Lead	Cost/Funding source
TBC	Membership mailing (including covering letter from Chairman, *Trust News*, Annual Members' Meeting invitation)	Communications Manager	£10,000 (Foundation Trust budget)
September 2013			
Friday 6 Sep	Members' News Issue 6	Head of Communications	£210 (Council of Governors)
Thursday 19 Sept	Annual Members' Meeting	Head of Communications	£5,000 (Council of Governors)
TBC	Medicine for Members seminar – Orthopaedics – Alison Hulme and Emer Bouerman	Communications Manager	£700 (Council of Governors)
October 2013			
Friday 4 Oct	Members' News Issue 7	Head of Communications	£210 (Council of Governors)
November 2013			
Friday 1 Nov	Members' News Issue 8	Head of Communications	£210 (Council of Governors)
TBC	Medicine for Members seminar – Care of the Elderly / Carers – Tony Pritchard	Communications Manager	£700 (Council of Governors)
December 2013			
Friday 6 Dec	Members' News Issue 9	Head of Communications	£210 (Council of Governors)
TBC	Christmas at Chelsea and Westminster event (mini Open Day)	Communications Dept	£8,000 (Council of Governors)

Date/Month	Event/Activity	Lead	Cost/Funding source
January 2014			
Friday 3 Jan	Members' News Issue 10	Head of Communications	£210 (Council of Governors)
TBC	Membership mailing for all public and patient members (including covering letter from Chairman, Trust News and A5 flyers about details of 'Medicine for Members' seminar and other future events)	Communications Manager	£10,000 (Council of Governors)
TBC	Launch of Star Awards nominations – Patient Choice category and Council of Governors Special Award	Communications Manager	Not from Council of Governors budget (Star Awards funded by Chelsea and Westminster Health Charity)
TBC	Medicine for Members seminar	Communications Manager	£700 (Council of Governors)
February 2014			
Friday 7 Feb	Members' News Issue 11	Communications Manager	£210 (Council of Governors)
TBC	Closing date for Star Awards nominations – Patient Choice category and Council of Governors Special Award	Communications Manager	Not from Council of Governors budget (Star Awards funded by Chelsea and Westminster Health Charity)
March 2014			
Friday 7 Mar	Members' News Issue 12	Head of Communications	£210 (Council of Governors)
TBC	Medicine for Members seminar	Communications Manager	£700 (Council of Governors)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 18 July 2013

AGENDA ITEM NO.	2.7/Jul/13
PAPER	Membership Recruitment, Engagement and Communications Strategy 2013-14
AUTHOR	Katie Drummond-Dunn, Communications Manager Sian Nelson, Membership and Engagement Manager
LEAD	Tony Pritchard, Acting Chief Nurse
EXECUTIVE SUMMARY	This paper sets out a membership strategy for approval by the Council of Governor.
DECISION/ ACTION	The Council of Governors is invited to comment on and approve this strategy.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

MEMBERSHIP RECRUITMENT, ENGAGEMENT AND COMMUNICATIONS STRATEGY 2013-14

1.0 Introduction

Since receiving authorisation as a Foundation Trust in October 2006, Chelsea and Westminster Hospital NHS Foundation Trust has made considerable efforts to build a membership that is vibrant and representative.

However, membership numbers steadily declined over a number of years since authorisation. This decline was masked by the decision post-authorisation to change staff membership from 'opt-in' (staff actively choosing to become members) to 'opt-out' (staff being members unless stating that they do not wish to be so) which boosted membership numbers by c.2,500.

During the last year there has been increased recruitment, engagement and communication activity.

- **Recruitment** - The number of members increased by 410 in 2012/13 compared with 2011/12
- **Engagement** - Members were actively engaged in the development of the Trust's values and the *Safe in our hands* campaign to save A&E in 2012
    - Members were invited to nominate staff for the 2013 Chelsea and Westminster Star Awards
    - 'Medicine for Members' seminars are now being run as extra membership events
    - There are two main engagement events for the Trust; Open Day which takes place in May and a new Christmas event that takes place at the beginning of December
- **Communication** – There are three membership mailings of Trust News each year (January/February, April/May and August/September) and monthly email newsletters are sent to our members at the start of each month

1.2 What does this strategy cover?

This strategy focuses on the two key areas of membership activity:

- Part A - Recruitment of new members and development of a representative membership
- Part B - Engagement and communication with existing members

The two areas are clearly linked - if we do not provide existing members with good enough reasons to retain their membership and play an active part in the hospital, they will leave and we will have to expend more energy and resources on recruiting new members to replace them.

1.3 Which Trust staff are responsible for membership?

Sian Nelson (Membership and Engagement Manager) is responsible for membership recruitment and the Communications team - Layla Hawkins (Head of Communications) and Katie Drummond-Dunn (Communications Manager) are responsible for engagement of and communication with members. There is strong interface with the Equality & Diversity Manager Priti Bhatt.

The Membership Sub-Committee of the Council of Governors, which is chaired by Public Governor Martin Lewis, oversees the membership strategy.

2.0 PART A – Membership Recruitment

The Trust's membership at the end of the 2012/13 financial year was 15, 268 - an increase of 410 members compared with 2011/12.

Constituency	31 March 2013	31 March 2012
Staff	3, 424	3,231
Patients	5, 994	5,685
Public	5, 850	5,942
Total	**15, 268**	**14,858**

Recruitment is an on-going activity because we need to recruit new members to maintain the current membership numbers – in order to replace members who move away from the area or who pass away.

2.1 Recruitment of new members

This strategy proposes that recruitment of new members should continue to focus on activities that are demonstrated to be effective and enable the Trust to develop a representative membership.

Recruitment should be systematic and evidence-based so that the Trust's limited budget for this activity is spent in a cost-effective way.

For example, in 2012/13 the Trust gained 600 new members through hospital-based recruitment drives. We outsource this activity to Capita Membership Services and this is a cost-effective way of recruiting new members.

It is proposed to run these events again in 2013/14 because they have proven to be successful in not only recruiting new members but also helping to publicise the Trust's Open Day, the Annual Members' Meeting and the Governor Elections.

In addition, the Open Day held in May each year is an opportunity for Governors to recruit new members – 107 new members were recruited at the 2013 Open Day.

The Membership and Patient Advice & Liaison Service (M-PALS) promotes membership by giving membership application forms to visitors to the M-PALS office in the hospital and sending out membership application leaflets with letters responding to comments received by M-PALS.

Other potential opportunities for recruitment of new members include the 'Meet a Governor' sessions in the hospital, local community events (eg open days, fairs, fetes etc) and ad hoc recruitment in GP surgeries but these should not replace the larger scale recruitment drives.

2.2 Development of a representative membership

Analysis of the membership database by age, gender and ethnicity is undertaken to help the Trust work towards developing a membership that is representative of the communities we serve.

It is recognised that membership recruitment should focus particularly on increasing the number of Black and Minority Ethnic (BME) members as well as other under-represented groups.

Working with our existing patient BME groups would be more logical than blindly recruiting public members who do not wish to, or actively use our hospital services. For example, previous attempts to recruit north of the Borough of Kensington and Chelsea and the Borough of Hammersmith and Fulham have failed due to the close proximities and connection these members of the public have with local hospitals in these areas, for example St. Mary's Hospital or the Hammersmith Hospital. It is proposed that we target our Trust's satellite clinics, which include the Dean Street Clinic, and the West London Centre for Sexual Health, which both have a culturally diverse patient population..

Membership recruitment has previously been successful with a Somali women's patient group at West London Centre for Sexual Health - it is proposed we re-target this group.

Alongside membership recruitment, it is important that we understand the needs of our members and learn about their experience of treatment and services. Therefore, we will seek ways to gather this information from the BME patient groups we recruit.

The BME Health Forum based in Kensington and Chelsea have proposed various ways of working with us to increase trust BME membership from their existing membership group. There are cost implications and therefore these will be presented to the Membership Sub-Committee.

PART B – Membership Engagement

3.0 Engagement and communication

Membership numbers alone are meaningless unless we engage with our existing members to give them reasons to maintain their membership and to fulfil our role as a locally accountable organisation.

3.1 Programme of activity 2013/14

The membership engagement programme for 2013/14 is the same as the strategy used in 2012/13 and funding was approved at the Council of Governors meeting on the 24 January 2013.

This programme is now being implemented – thanks to funding from the Council of Governors budget.

In 2013/14 the Council of Governors has provided funding of £50,600 to support the following activity:

Project	**Funding**
3 membership mailings per year (One issue funded by the Council of Governors)	£10,000
Open Day 2014	£20,000
Annual Members' Meeting	£5,000
6 Medicine for Members seminars	£5,000
Christmas at Chelsea and Westminster 2013	£8,000
12 Members' e-News	£2,600
Total	£50,600

3.2 Campaigns to engage members in key issues

The ***Shaping a healthier future*** public consultation about proposed changes to NHS services in North West London closed in October 2012 but we will continue to communicate with members and Governors until a final decision is signed off.

May 2013 marked the Trust's ***20th anniversary*** which was celebrated at the open day. There will be further opportunities to engage members with the Trust's 20th anniversary later in the year and plans are currently being drafted by the communications team.

3.3 'Meet a Governor' sessions

These sessions are communicated to members in advance through the *Trust News* membership mailings, the monthly *Members' News* email newsletters, and via the 'Get Involved' section of the Trust website.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 18 July 2013

AGENDA ITEM NO.	2.8/Jul/13
PAPER	Annual Members' Meeting proposal
AUTHOR	Layla Hawkins, Head of Communications & Marketing
LEAD	Layla Hawkins, Head of Communications & Marketing
EXECUTIVE SUMMARY	This paper is intended to propose the format of this year's Annual Members' Meeting on Thursday 13 September and other events to be organised for Foundation Trust members and prospective members during September. The Annual Members' Meeting is a statutory requirement and must include presentations by the Chairman, Chief Executive, Director of Finance and a Governor – it is also proposed this year to include presentations by clinicians. A number of other events are proposed to be organised for members during September.
DECISION/ ACTION	Governors are invited to put themselves forward to present the membership report on behalf of the Council of Governors.

ANNUAL MEMBERS' MEETING PROPOSAL

The Annual Members' Meeting will be held at **5.30pm** on **Thursday 19 September** in the Restaurant on the Lower Ground Floor of the hospital.

All Board members – both Executive and Non-Executive Directors – are expected to attend.

The meeting is organised by the Head of Communications & Marketing on behalf of the Chairman and Chief Executive.

In previous years this has been a well-attended event with several hundred Foundation Trust members and hospital staff in attendance.

Our Foundation Trust constitution sets the following requirements for the meeting:

- The Board of Directors shall present to Foundation Trust members the annual report and accounts 2012/13; report of the external financial auditor (included in the annual report and accounts); forward planning information for 2012/13
- The Council of Governors shall present to Foundation Trust members a report on steps taken to ensure that the membership of the Trust is representative of those eligible for membership of the public, patient and staff constituencies; progress on the membership strategy; results of Council of Governors elections; announcement of Non-Executive Directors appointed in 2012/13

For action

- If any Board members are unable to attend the Annual Members' Meeting, please notify Layla Hawkins in advance.

2. Specific issues surrounding this year's Annual Members' Meeting

Changes to the structures of the NHS have had an impact on the funding flow for sexual health services and this will form a key component of the clinical presentations. This is timely as the Dean Street Express facility will open in October 2013 and it is an opportunity to showcase this and other innovations that will further improve the provision of sexual health care and advice by the Chelsea and Westminster team.

The second presentation will be a review of research endeavours involving the Trust over 2012/13, led by CLAHRC.

We would also like to recognise the spring winners of the quality awards as part of the meeting schedule as quality is a key focus of the report and the event would provide an excellent showcase of individual and team achievements.

As it is the 20th anniversary of the opening of the main hospital building we would like to show the original video of the hospital opening and then a new video highlighting our achievements and innovation over the last 20 years.

Issues that could be raised as questions may include (but aren't limited to):

- Finances
- Sexual health funding
- Chelsea Children's Hospital
- Charitable donations and investments

- Partnership working with either West Middlesex University Hospital NHS Trust or the Royal Brompton & Harefield NHS Foundation Trust

3. Aims and themes

3.1 Aims

The Annual Members' Meeting should be a positive event which enables the Board and the Council of Governors to set out the key achievements of the last financial year and plans for the current financial year.

The meeting should also aim to create a genuine dialogue with Foundation Trust members by providing them with an opportunity to ask questions of the Board of Directors and to provide their feedback on the Trust's performance and future plans.

3.2 Themes

It is proposed that the overarching theme of the Annual Members' Meeting should be the 20th anniversary.

For action

- The Board is invited to comment on the proposed aims and themes of the Annual Members' Meeting.

4. Proposed format of the meeting

4.1 Annual Members' Meeting opens with original video of hospital opening (5 minutes)

4.2 Statutory presentations (5-10 minutes maximum for each speaker):

1. Chairman
Content to be discussed nearer the time.

2. Chief Executive
Content to be discussed nearer the time.

3. Director of Finance
Presentation of accounts and brief overview of our financial position, in particular how we have used our Foundation Trust freedoms to invest our surplus in developments to improve patient care.

4. Council of Governors representative (TBC at July Council of Governors meeting)
Membership report to include an explanation of the role of Governors and the role of members and Governors in supporting the Trust.

4.2 Question & Answer session (30 minutes maximum)

Questions from the public to be answered by the Trust Board of Directors – this session will be chaired by the Chairman.

4.3 Presentations by clinicians (10 minutes each)

For action

- The Board is invited to comment on the proposed format of the meeting and to discuss the suggested topics for the presentations by clinicians.

4.4 Votes on proposed changes to the Foundation Trust constitution

If votes on proposed changes to the constitution are necessary, full details must be included in both the Foundation Trust membership mailing which is sent out to all patient and public Foundation Trust members in August to publicise the Annual Members' Meeting and the agenda/programme provided at the meeting itself.

For action

- The Director of Governance & Corporate Affairs is asked to advise the Head of Communications if any votes on changes to the constitution are required.

4.5 Announcement of Spring Quality Awards winners (5 minutes)

4.6 Annual Members' Meeting closes with 20th anniversary video (5 minutes)

Layla Hawkins
Head of Communications & Marketing
July 2013

Council of Governors Meeting, 18 July 2013

AGENDA ITEM NO.	2.10/Jul/13
PAPER	Governors' Questions
AUTHOR	Deirdre Linnard, Head of Pharmacy Tony Pritchard, Acting Chief Nurse
LEAD	David Radbourne, Chief Operating Officer
EXECUTIVE SUMMARY	The question raised by Anna Hodson-Pressinger 'My question is on the fake medicines which are coming in huge quantities into Britain now and even into the NHS. They are so well packaged that they foul doctors. Around the World these criminals sell their stuff mostly through the Internet but directly through their agents or they get into the hands of agents having been whitewashed. This is a very serious crime which could very well affect us as a hospital, so alerts need to be regularly sent around the appropriate areas, there have been deaths in USA of some 80 babies who were given some made-up medicine for teething which was just ammonia and in South America there was last year deaths of several hundreds from some so-called medicine which had rat-poison in it. These criminals making it are mostly in South America and China, but criminal gangs here and all over the world get their hands on it as there is billions been made from it as there is more to be made from selling these made-up medicines than from narcotics/drugs. The NHS the police interviewed on television the other day say is the main arena in this country in which these criminals want to sell these to as the NHS has the biggest fund for buying. I will be approaching my MP and others who matter in Government as there has to be a major alert and something done about it. So we need to be very vigilant and aware. Response: **Response from Pharmacy C&W** Reports about fake medicines are very concerning. It is reported that counterfeiting is most associated with blockbuster 'lifestyle' medicines made by unregulated manufacturers in developing countries and sold through illegitimate websites. However, we are very aware of this risk and have measures in place to prevent fake medicines entering the supply chain. **EU regulation and the MHRA** The EU has a strong legal framework for the licensing, manufacturing and distribution of medicines. At the end of the distribution chain, only licensed pharmacies and approved retailers are allowed to offer medicines for sale. In July 2011, the EU strengthened the protection of

	patients and consumers by adopting a new Directive on falsified (fake) medicines for human use. This Directive aims to prevent falsified medicines entering the legal supply chain and reaching patients. It introduces harmonised safety and strengthened control measures across Europe by applying new measures. 1. Safety features of medicines e.g. barcode and tamper evident packaging 2. Supply chain and good distribution practice 3. Active substances and excipients i.e. all raw materials must be certified All members of the EU had to start applying these measures in January 2013. In the UK this is managed by the MHRA (Medicines and Healthcare Products Regulatory Agency). In June 2013, counterfeit drugs valued at £26.8m were annexed internationally of which £12.2m was seized by the MHRA. Rather than being an indicator that the problem is particularly bad in the UK, this is a positive indicator of the proactive approach of the MHRA and also because illegal products are being shipped via the UK to give the illusion of legitimacy. How do we ensure that we don't allow 'fake medicines' into the supply chain at Chelsea and Westminster Hospital? It is the responsibility of the Pharmacy at Chelsea and Westminster Hospital, as described in the Trust Medicines Policy, to procure and supply all medicinal products for the Trust and to ensure that medicines are procured from a reputable source and are of appropriate quality. Identification of potential sources of supply, specification of the medicine for its intended use, consideration of other issues such as lead times and shelf life as well as the method of procurements are considered. Pharmacists have a legal and professional duty to ensure the safe, accurate and clinically appropriate dispensing of medicines, including those that are extemporaneously prepared. Most of the medicines we purchase are licenced and are obtained directly from an MHRA regulated pharmaceutical company in the UK or via an MHRA regulated Pharmaceutical Wholesaler. This means that these suppliers must adhere to supply chain and good distribution practice and are inspected regularly by the MHRA. We also buy some specialised medicines for individual patients where a standard U.K. licensed product does not meet that patient's need. We purchase these items from specialist suppliers in the UK and they must come with quality control certification, which is verified by our Quality Assurance Service based at Imperial College Hospitals NHS Trust. Before we add any new supplier to our pharmacy system, we check their status on the MHRA website to ensure they are approved and licensed to supply the types of product we want to buy from them. Pharmacy staff are also vigilant for any variations in packaging or appearance that might indicate that a fake medicine had entered the supply chain and our Medicines Policy is clear on the action we soul take if this is suspected. I hope this reassures our Governors that Pharmacy takes this concern very seriously. Constant vigilance and only buying from reputable suppliers is the key to prevention. The questions raised by Harry Morgan

	1. Last November Tony Pritchard convened a well-attended meeting on the subject of Home Care and how it could be improved. Is there anything further to report? Response: Carers Forum Progress Update - July 2013 **1. Introduction** 1.1. We developed a Carers Forum in October 2012. The aim of this is to develop our partnership working with informal carers during the patients stay, and to support carers through appropriate referral to other agencies in social care and the voluntary sector. 1.2. The forum has representation from a range of health, social care and voluntary roles along with carer representatives. The group meets each quarter and is chaired by the Acting Chief Nurse. Within the forum, we take forward detailed work between these meetings with representatives from social services and Carers UK **2. Key developments** The following summarises the key areas of work to date; 2.1. We have developed a carers strategy which sets out our intentions and objectives in supporting carers 2.2. We have mapped the referral processes between our own services and those of Social Services and voluntary organisations 2.3. We have established an intranet folder so that staff can easily access relevant information on carer information 2.4. Key information for carers has been provided so that our Patient Advice and Liaison Service can reference this. 2.5. We have developed a questionnaire for carers of those with dementia which is conducted with the carer following an admission to hospital 2.6. Carers UK had an information stand at our Patient Experience Summit in July 2.7. A carers care plan has been developed and introduced to our ward areas 2.8. We have begun to draft best practice guidance for carers **3. Future objectives** 3.1. We will complete work on our best practice guidance for working with carers 3.2. We plan to run awareness sessions for groups of staff across the trust, along with a poster campaign 3.3. We aim to develop more diverse carer representation in our forum 3.4. We will develop a wider carer survey to gauge our current support and how this can be enhanced. 2. Are there any plans to raise the standard of goods on sale on the ground floor from time to time? Response: Martin Lewis, Chair of Friends will provide oral response at the Council of Governors meeting.

	Are there any plans to raise the standard of goods on sale on the ground floor from time to time? The questions raised by Chris Birch 1: Is it still planned to name some part of the Ron Johnson ward after Jim Smith? 2: What is the Board of Directors planning for its official opening? 3: Can we please mention somewhere that the Ron Johnson ward replaces the old Thomas Macaulay ward? Response: David Radbourne, Chief operating Officer will provide oral response at the Council of Governors meeting.
DECISION/ ACTION	To note.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 18 July 2013

AGENDA ITEM NO.	2.11/Jul/13
PAPER	*Council of Governors Funding Report
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Vida Djelic, Foundation Trust Secretary
EXECUTIVE SUMMARY	This paper provides an update on the Council of Governors budget for the FY 2012/13 and 2013/14.
DECISION/ ACTION	The Council of Governors is asked to note the report.

Council of Governors Funding Report

1.0 Background

A decision was made at the November 2008 Council of Governors meeting that a budget should be available to the Council of Governors to spend at their discretion on relevant projects. This is £80,000 for the financial year 2013/14.

2.0 Funding Overview for 2012/13 and 2013/14

Of the £80k circa £73k has been committed to the activities listed in the table below which were approved by the Council of Governors.

Of the £80k circa £55k has been committed to the activities listed in the table below which were approved by the Council of Governors. It leaves circa £25k available for the reminder of the year 2013/14.

Use of funds FY 12/13

Date Presented	Projects	Amount Committed	Decision	Spent to date
June 2010 and recurring	Quality Awards	£2,000	Agreed 2012/13 FY	£1,000
December 2011	Open Day 2012	£15,000	Agreed 2012/13 FY	£12,904.22
December 2011	Engagement Activity - Membership mailing (Jan 2013)	£10,000	Agreed 2012/13 FY	£8,911.86
December 2011	Engagement Activity - 12 Members' News monthly emails (April 2012-March 2013)	£2,520	Agreed 2012/13 FY	£1,080
December 2011	Engagement Activity - Annual Members' Meeting + 2 associated events (Sept 2012)	£5,000	Agreed 2012/13 FY	
December 2011	Engagement Activity - 5 'Medicine for Members' events	£5,000	Agreed 2012/13 FY	£283
December 2011	Engagement Activity - Christmas event (Dec 2012)	£5,000	Agreed 2012/13 FY	£5,658.14
February 2012	Small Membership branded gifts for the Open Day May and Annual Members' Meeting September 2012	£1,500	Agreed 2012/13 FY	£1,873.55
February 2012	Members Recruitment Campaign for Open Day May 2012	£2,340	Agreed 2012/13 FY	£2,500
May 2012	Open Day 2012 advertising via letterbox drop and in the local press	£4,793	Agreed 2012/13 FY	£4,093
May 2012	Giggle Doctors	£4,600	Declined	NA
July 2012	Membership recruitment session September – additional funding	£1,260	Agreed 2012/13 FY	
December 2012 February 2013	Free-standing banner in Information Zone Additional funding for a free-standing banner in Information Zone	£250 £28	Agreed 2012/13 FY Agreed 2012/13 FY	 £278
February 2013	Membership branded gifts for the Open Day May 2013 recruitment	£3,455.74	Agreed 2012/13 FY	

February 2013	Free-standing banner to promote membership			£273
April 2013 (via email)	Information resource booklet for patients, users of Trust services, governors and staff	£3,500	Agreed 2012/13 FY	
April 2013 (via email)	Intranet/internet resource for staff, governors and users of the Trust's services regarding the CQC standards	£11,000	Agreed 2012/13 FY	
	TOTAL 2012/13 FY	**72,636.74**		**£36,431.82**

Use of funds FY 13/14

Date Presented	Projects	Amount Committed	Decision	Spent to date
July 2012	Open Day 2013	£20,000	Agreed 2013/14 FY	£19,736.34
February 2013	Members Recruitment Campaign for Open Day May 2013 and elections	£2,340	Agreed 2013/14 FY	
February 2013	Members Recruitment Campaign and promotion of the Annual Members Meeting (within the hospital)	£1,170	Agreed 2013/14 FY	
February 2013	Members Recruitment Campaign and promotion of Governor Elections (incl. within the community)	£1,170	Agreed 2013/14 FY	
February 2013	3 membership mailings per year	£10,000	Agreed 2013/14 FY	
February 2013	Annual Members' Meeting	£5,000	Agreed 2013/14 FY	
February 2013	Medicine for Members seminars	£5,000	Agreed 2013/14 FY	
February 2013	Christmas at Chelsea and Westminster	£8,000	Agreed 2013/14 FY	
February 2013	Members' e-News	£2,600	Agreed 2013/14 FY	£648
	TOTAL 2013/14 FY	**55,280.00**		**£20,384.34**

3.0 Progress report re projects for FY 2013/14

4.1 An update on projects re membership engagement is outlined in the paper 2.6.

4.2 For an update on projects re the Members Recruitment Campaign see membership report paper 2.19.

4.3 Quality Awards – to be presented at the Council of Governors meeting on 18 July 2013. .

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 18 July 2013

AGENDA ITEM NO.	2.12/Jul/13
PAPER	*FTGA/NHS confederation joint event - NEDs and governors: How to build effective working relationships 22 April 2013
AUTHOR	Susan Maxwell - Patient Governor
LEAD	Susan Maxwell, Patient Governor
EXECUTIVE SUMMARY	The FTGA held their first-ever joint session with the NHS Confederation on 22nd April this year. This was one of three roundtable sessions held at various locations across the UK, with the other two to be held in May and June. The exercise was to investigate mutually agreeable means for Governors and NEDs to form an effective working relationship.
DECISION/ ACTION	The Council is asked to note the paper.

FTGA/NHs confederation joint event - NEDs and governors: How to build effective working relationships 22 April 2013

The tables had a good mix, with people being rotated so that we all met a fairly comprehensive mix of people from various FTs and heard varied reports of what was happening in the Trusts.

Most of the governors in the room did not have a NED representative from their Trust in the groups, and it is interesting to note that most of these claimed that they did not meet their NEDs on a level of getting to know them well enough to engage in conversation.

Of the NEDs who did attend, I was greatly impressed by those who had found time to come and put their point of view. Most of them were already meeting up with their governors, and they agreed that they had found this beneficial.

The main complaint from those NEDs present was that they were already giving up their contracted time to Trust matters, with most of them giving more hours than they have ever anticipated when they became NEDs. Any time they were giving to mixing with governors, other than on ward rounds, was therefore on their own time.

All agreed that this was a hurdle that should be overcome, since it was also agreed that it was in the best interests of the Trusts that a good working relationship should be in place between NEDs and Governors.

The attached discussion paper has been issued by the NHS Confederation (produced in association with the FTGA). It was drawn up after all three sessions were completed. I think it is an informative read.

Susan Maxwell
Patient Governor

NHS CONFEDERATION

discussion paper

June 2013 Issue 15

A match made in heaven?

How NEDs and governors can form effective working relationships

Key points

- Relationships between NEDs and governors should be built at an institutional and personal level.
- Joint training and development programmes support both knowledge acquisition and relationship-building.
- The chair of the Board of Governors has a pivotal role in building strong relationships between governors and NEDs.
- The 'Nolan Principles' of public service and the NHS Constitution offer guidelines for the creation of shared values.
- An effective appointment process, with appropriate governor involvement, is integral to the selection of high-calibre NEDs.

The Health and Social Care Act 2012 was the most extensive restructure of the NHS to date, impacting on all parts of the NHS, including the governance arrangements of foundation trusts. Indeed, the Act is particularly significant for foundation trust governors, because it reinforces their role and means that they must do more to hold their boards and directors to account. It is also clear that the Act places far greater emphasis on local responsibility and accountability; accordingly foundation trust governors have been given new responsibilities, including those related to how they work with non-executive directors (NEDs).

This paper outlines the key themes from the discussions at a series of round-table events and highlights the barriers that need to be overcome to make relationships between NEDs and governors more effective. The paper also explores some processes and activities that might improve relationships, with the aim of helping NEDs and governors to understand each other's roles better and, by doing so, improve the governance of foundation trusts.

The Act states: "The general duties of the council of governors are to hold the non-executive directors individually and collectively to account for the performance of the board of directors." This new requirement involves two main tasks, namely assessing how well (or not) the NEDs are scrutinising the board, and scrutinising the board directly. This adds an extra layer of scrutiny and assurance within the governance structure of foundation trusts, which is supposed to aid the discovery of any issues early on, so that they can be addressed before they become more serious.

Produced in association with

FTGA Foundation Trust Governors' Association
Debate | Exchange | Learn

'A culture of mutual respect, openness and transparency should be fostered at all foundation trusts'

In order to hold NEDs to account effectively, it is important to have a good understanding of their activities. The stipulation that they should be held accountable both 'individually and collectively' highlights the need for governors to examine the performance of individual NEDs, not just the NEDs together in a group. In order to do this, it can be very helpful to build relationships with NEDs, to understand exactly how they work and what they do.

This is especially important, given the tensions that are often found between governors and NEDs. These tensions mean that NEDs may not always be happy to have their work scrutinised by governors whom they may misunderstand, mistrust or have little respect for. In this situation, governors may find it very difficult to get meaningful information from NEDs. For their own part, governors may not understand the roles of the NEDs or how best to ask questions and work alongside them.

Mindful of these concerns and keen to find a way to address them, the Foundation Trust Governors' Association (FTGA) – the national organisation for foundation trust governors – and the NHS Confederation hosted a series of round-table events in spring 2013, designed to bring NEDs and governors together in an atmosphere of candour. In an effort to encourage NEDs and governors to share examples of best practice and to jointly devise solutions to any challenges they were facing, the discussions centred around two key questions:

- NEDs and governors – a match made in heaven or a disaster waiting to happen?
- How can NEDs and governors form effective working relationships?

Encouragingly, during each event it was clear that governors and NEDs felt able to challenge each other, to negotiate ways of working and to accommodate their different perspectives. This culture of mutual respect, openness and transparency should be fostered at all foundation trusts in order to support the ways of working suggested in this paper.

Working together

The importance of understanding, respecting and valuing each other's roles was seen by governors as essential to allowing them both to better fulfil their duties and build more effective relationships.

It was clear from the discussions that strong working relationships between NEDs and governors exist in many foundation trusts. This relationship is fostered by regular meetings, joint working and opportunities for socialising. However, participants also highlighted weak and in some cases almost non-existent relationships. Many NEDs and governors said that they had not met, either formally or informally. Some attendees said that they felt there was a lack of trust between NEDs and governors as well as confusion about their roles.

All the participants agreed that to overcome these barriers it is necessary to nurture the relationships between NEDs and governors at both an institutional and at a personal, social level. They agreed that relationship-building was particularly important if governors and NEDs are going to understand, respect and value each other's roles.

'The establishment of some formal processes was felt to be desirable'

Case study: NAGG, Southend University NHS Foundation Trust

Southend University NHS Foundation Trust has established a NEDs and Governors Group, known affectionately as 'NAGG'.

- All NEDs and governors are invited to attend quarterly meetings; these also provide an opportunity for some pre-meeting socialising. The meeting is chaired by the chair of governors and has developed terms of reference to guide its work. The agenda is set by governors prior to the meeting.
- Governors attend the (non-public) meeting, which is held to provide quarterly monitoring review letters and executive feedback from Monitor.
- NEDs attend all governors' council meetings and a NED sits on each of the governors' tables to facilitate interaction.
- NEDs attend member and public meetings that are arranged by the trust, so that governors can meet the members and the public.
- NEDs attend and provide support at governors 'listening exercise' events, which are held twice yearly.
- Each of the governor committees (Search and Appointments, Governance Strategy, Patient and Carer Experience, Membership Engagement and Recruitment, Education and Training, Editorial Advisory Board and Worker Governors) all have at least one NED, sometimes two, assigned to them as liaison for the committee.
- NEDs are supposed to work three days a month, but it is recognised that the NEDs at Southend probably do at least twice as much during most months, recognising the work that they need to do with governors.
- The trust is currently updating their in-house training programme for governors, with governors playing an active role through the Education and Training Group.
- The trust is beginning ward walks for governors. NEDs and executives already participate in ward walks and they have now invited governors to attend. NEDs do two walks a month on average and they will now allow two governors to attend with each NED. Their findings will be reported back. Issues of interest to governors can also be taken up through the governors' Patient and Carer Experience Group, the NED liaison for which is also the chair of the Board Quality Assurance Committee.

Building relationships

Attending meetings

To support better relations between NEDs and governors, the establishment of some formal processes was felt to be desirable. In particular, participants felt it was very important that NEDs and governors attended each other's meetings. The importance of having an 'open door' policy for governors was stressed: governors should feel free to attend NEDs' committee and sub-committee meetings, to observe the process and to get a better understanding of roles. Equally, it was suggested that NEDs should attend Governors' Council meetings, and meetings with members of the public, so that they could hear their views first-hand.

Communication

All participants suggested that improving communication between NEDs and governors was important in making their relationship more effective. It was highlighted that in order to effectively fulfil their roles, communication needed to be genuinely two-way, and that opportunities for dialogue and discussions should be facilitated.

Joint meetings

To develop the relationship further and encourage dialogue and communication, there is a need for more joint working, joint meetings and integrated committees. One group reported that they held joint governor–NED meetings, in which particular tasks and strategic issues were discussed in small groups. These meetings provided an opportunity to get to know one another and encouraged participants to arrive at joint conclusions on important issues.

Development areas

Three areas where it was felt that governors and NEDs could do more together to nurture cooperation and mutual respect are highlighted below.

Joint training and development – Participants felt strongly that there was real value in a model of shared learning for NEDs and governors. Some suggested that looking at procedures together was important and that joint training on, for example, information protection, and sessions based around patient experience, could be useful ways of assuring that NEDs and governors had the same level of understanding, as well as offering an opportunity to meet each other in a different context.

> 'The chair of the Board of Governors had a pivotal role in determining the culture of the board and in building strong relationships between governors and NEDs'

Joint workshops – Participants reported how they had used joint workshops to share feedback informally, following a review of the Council of Governors and the board. They suggested that the informal nature of the workshop allowed for a very frank and open discussion in which everyone felt they could contribute, aiding learning and development.

Joint activities – It was felt that getting to know one another in informal settings was important. Participants suggested that this could be partly achieved through social interaction before or after joint meetings or committees. Some reported that they had developed their own procedures and practices to help nurture these relationships informally. These included:

- annual 'Coffee with the Chair' sessions, which NEDs and governors were both invited to attend
- regular ward rounds, undertaken jointly by a selection of NEDs and governors
- time for discussion being set aside before and after joint meetings.

Leadership

Establishing the culture

Participants agreed that the chair of the Board of Governors had a pivotal role in determining the culture of the board and in building strong relationships between governors and NEDs. Some described the role of the chair as a 'matchmaker' who should actively encourage governors to attend meetings of the board, as well as organise joint activities. The chair was seen as the person responsible for ensuring that there was strong communication and engagement between the board and NEDs, as well as with staff and the public. The lead governor also plays a critical role in ensuring that the board is effective. Their role is to facilitate direct communication between Monitor and the NHS foundation trust's board of governors.

Relationships

The relationships between the chief executive, the chair and the lead governor of foundation trusts were considered particularly important. It was felt by many that as long as these players had a good understanding of their roles and had good lines of communication then this would enable a better flow of information.

Case study: Tees, Esk and Wear Valleys NHS Foundation Trust

Tees, Esk and Wear Valleys NHS Foundation Trust recognises that its size, covering County Durham, Teesside, most of North Yorkshire and Wetherby in West Yorkshire, and its geography, encompassing coastal, rural and industrial areas, both create significant challenges in fostering close working relationships between governors and NEDs.

The trust has developed a number of initiatives to enable NEDs and governors to appreciate each other's roles, develop mutual respect and understanding, and focus on areas of common interest. These include:

- Each NED is assigned a specific constituency within the geographic area covered by the foundation trust. They then act as the focal point for the governors who represent that constituency.
- Board/council of governors' steering groups support joint working on key governance issues, for example overseeing tendering for the external audit provider and in reviewing the constitution.
- Time is set aside before each meeting of the council of governors, to provide networking opportunities.
- Governors and NEDs attend constituency meetings.
- Governors attend structured board visits to services alongside NEDs.
- Governors are appointed to key working groups (such as the equality and diversity, patient experience and workforce steering groups) allowing them to observe the work of NEDs first-hand.
- The trust chairman actively encourages governors to attend meetings of the board: four meetings a year are held away from the trust's headquarters to make it easier for governors to attend.
- NEDs are invited to biannual governor development days, facilitating shared learning.
- Governor/NED relations are tested annually, as part of the trust's performance evaluation scheme.

Shared aims and values

Having a common purpose and sharing the same values was given a great deal of importance by both NEDs and governors, who agreed that these were important in ensuring that the organisation was cohesive. The seven 'Nolan Principles'* and the NHS Constitution[1] were cited by participants as being important guidelines for creating shared values and ongoing development of a shared purpose. However, there was also recognition that more should be done to ensure both that newly appointed governors understand the purpose of their roles and that they were aware of, and share the values of, the NHS. This could be achieved through the governors' induction process, initial training or an induction training manual.

Encouraging diversity

Diversity on boards was something that many participants felt should be encouraged as without it, they could succumb easily to 'groupthink'. Furthermore, many underlined the need to give people the opportunity to speak, respecting different ways of thinking as well as differences in gender, age and ethnicity.

* The seven 'Nolan Principles' of public life are selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

Participants called for some NEDs and governors to be selected for their specific expertise and knowledge. For example, they highlighted the need for 'smart NEDs' and 'smart governors' who were able to specialise effectively in, for example, finance or patient safety.

Getting recruitment right

The selection of NEDs was seen as being important for ensuring that the relationship with governors is effective. It was suggested that NEDs needed to be recruited for their skills and their values. Participants felt that it was very important that NEDs and governors recognised their common purpose in improving healthcare, protecting patient safety and doing what is best for patients. Knowledge of the specific foundation trust and the sort of pressure faced on a day-to-day basis was also seen as important.

Both a good nominations committee and appointment process were considered key to achieving this, and to recruiting effective NEDs and governors. It was felt that governors needed to understand what the balance of the board should be, but were not always aware of the nomination process. The importance of having a good nominations committee and of taking outside advice on appointments when necessary were both highlighted as integral to selection of the right NEDs. Many governors thought they should have broad involvement in the short-listing criteria and selection of NEDs, in order to be assured of their independence and commitment.

'Participants felt that it was very important that NEDs and governors recognised their common purpose in improving healthcare'

Conclusion

This paper has highlighted that the means of building more effective relationships between NEDs and governors is not simply limited to attending board meetings together. Instead, relationship-building needs to be ongoing, and foundation trusts should draw upon a variety of different formal and informal methods to encourage NEDs and governors to get to know one another and to understand each other's roles better. Through creating the opportunities for NEDs and governors to interact, as well as through joint training and learning, it is believed that a mutual understanding of each other's roles is possible and a shared purpose can be created. There are already some good best practice examples of NEDs and governors working well together in foundation trusts. We need to learn from these examples, while also recognising there is no 'one size fits all' solution that will ensure effective working relationships. Foundation trusts need to develop their own tools that are relevant and fit with the way they work, and they need to nurture the relationships that they already have.

The round-table events on which this discussion paper is based have proven that there is an appetite among both governors and NEDs for making sure that the governance of foundation trusts is effective. The NHS Confederation and the FTGA will continue to work together to provide support and guidance, to help improve how NEDs and governors work together.

Case study: Moorfields Eye Hospital NHS Foundation Trust: Audit Committee working with governors

The chair of the Audit Committee at Moorfields attended a Governors' Council meeting and noticed that the questions asked in the Membership Council showed a real need for governors to better understand the duties carried out by internal and external auditors, as well as statutory board committees such as the Audit Committee. The chair also recognised the need to ensure that governors had effective support in reviewing the trust's financial stewardship through the annual report.

The main challenge was the need to provide the necessary tools and information for governors to have an appropriate grasp of both the financial and non-financial results for the year. As an initial measure, the chair of the Audit Committee worked with Moorfields' director of corporate governance to agree a training structure, focused initially around the financial reports but also allowing for any comments on clinical services or other corporate performance to be heard.

The first session, in June 2010, was chaired by the Audit Committee chair. Governors received an outline of the structure and format of the annual report and accounts. The finance director provided a straightforward report to show the financial performance for the year and the director of corporate governance supported governors by collating the questions and comments raised.

The Audit Committee chair was able to advise on the themes of questions that were within the role and scope of the external auditors, using the session as another opportunity for governors to learn about the role, the differences between internal audit, external audit and counterfraud/security, and about the activities of the committee itself.

Presenting summary financial information to support governors' understanding of the audited accounts was a useful, if initially challenging, activity. The final presentation format provided information that was simple but allowed the non-financial governors to ask questions and identify the key drivers for performance. Governors were then able to suggest questions on the financial information and the work done by external auditors for the quality report.

Governors also had a number of comments and questions on areas of quality, centred on clinical outcomes and patient experience and satisfaction – these were collated under themes and passed to the board and management for response.

In its second year, the session was facilitated by the director of corporate governance and was part of the induction provided to newly elected governors.

References

1. HM Government (2013) *The NHS Constitution for England*.
https://www.gov.uk/government/publications/the-nhs-constitution-for-england

Acknowledgements

The NHS Confederation and Foundation Trust Governors' Association would like to thank Dean Fathers, Chair, Nottinghamshire Healthcare NHS Foundation Trust, who led the round-table discussions, as well as all those NEDs and governors who took part.

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For more information about the issues covered in this paper please contact matthew.macnair-smith@nhsconfed.org

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Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 18 July 2013

AGENDA ITEM NO.	2.13/Jul/13
PAPER	Palliative Care at Chelsea and Westminster
AUTHOR	Chris Birch, Patient Governor, with comments by Anna Hodson-Pressinger, Patient Governor
LEAD	Chris Birch and Anna Hodson-Pressinger
EXECUTIVE SUMMARY	A brief account is given of the hospital's newly re-formed End of Life Care Quality Improvement Group and two ward rounds with our Consultant in Palliative Care.
DECISION/ ACTION	The Council is asked to note the report and that 'To improve choice and quality in end of life care' is one of our four quality priorities.

Palliative Care at Chelsea and Westminster

Membership, aim and terms of reference

I joined the End of Life Care Quality Improvement Group in March. That meeting was the third meeting of the group since its reformation. Anna has been a member from the start.

The group is chaired by Dr Richard Morgan, as Clinical Lead for Medicine, and is attended by Dr Sarah Cox, our Consultant in Palliative Care, and the Chief Nurse, the Palliative Care Nurse Specialist, the Medical Matron, representatives of the Acute Assessment Unit, the Ron Johnson and others.

The group looks at the last year or so of life of patients, some of whom will die at Chelsea and Westminster but some of whom will be seen in an outpatient clinic or have an admission in their last year but die elsewhere. The aim of the group is to improve the end of life care. This includes the last hours of life and therefore the Liverpool Care Pathway.

The Council will be familiar with the Liverpool Care Pathway concept, following the presentation at our 6 December meeting. I fully support the use of the LCP as a tool that has to be used properly. The group feels that the use of the term 'Liverpool Care Pathway' is not helpful and talks instead of 'the integrated care pathway for the dying'.

In particular the group is looking at adapting the 2011 VOICES national pilot bereavement survey questionnaire to get feed-back from the relatives of patients who have died at Chelsea and Westminster.

The group meets every two months and reports to the Trust's Quality Committee.

Palliative care ward rounds

Our Consultant in Palliative Care, Dr Sarah Cox, who also works at Trinity Hospice on Clapham Common, does ward rounds here at Chelsea and Westminster on Mondays and Thursday. She invited me to accompany her on two of these rounds on Monday 4 March and Monday 11 March. Anna is hoping to join Dr Cox on her rounds on a future occasion.

The wards visited included the Acute Assessment Unit, the Annie Zunz ward, the David Erskine ward, the Edgar Horne Ward, the Lord Wigram ward, the Nell Gwynne ward, the Rainsford Mowlem ward and the Ron Johnson ward.

On some wards only one patient was visited: on others two or three. In a few cases the patient did not want me to be present. The first ward round took two hours; the second three and a half. At the end of each round I was exhausted and totally drained.

The patients varied greatly from those very close to death to those who were not so close and from those who accepted that they were dying to those in denial. In some cases the patient was alone; in others one or more relatives or friends were at the bedside.

In many cases the patient and/or their families and friends sang the praises of our hospital and the quality of care provided. In every case the conduct of Dr Cox and her team was exemplary. Even in the case of one particularly challenging patient, Dr Cox was as patient, helpful and compassionate as with all the others. I was most impressed.

Anna Hodson-Prressinger comments: The Liverpool Care Pathway is not a policy I agree with as it is open to be abused and has gathered a lot of valid negative press coverage. But as it is the approved care that the Government and the Health Minister have rubber-stamped as the way that all hospitals should follow, we have to work with it. I wrote to the Minister of Health who sent me a standard reply showing me that he is not ready to enter into the debate.

So as it the guide that hospitals follow when they decide a person will die, I strongly believe in getting involved on this committee for better End of Life Care. I feel we have to work within the committee to improve and help direct those in our hospital to use the LCP in the correct and better manner when it is decided to be used (a very relevant point.) After reading the document which is not readily available, I realise that if it is followed correctly with true compassion and real medical responsibility and without the blazy attitude that daily witness to death can bring, the LCP guide can help the end of life care for individuals who are going through the last days/hours of their life with comfort to their families.

Problems occur in our hospital and in others with doctors and nurses effecting the LCP route firstly by them not discussing and seeking the agreement of the families to follow the LCP and the families and loved-ones knowing and understanding what it is and what it entails. Of course, they are meant to inform the patient and seek his or her permission, which is not always wanted or appropriate. I personally had this experience of not being asked or allowed to make that decision. Often this pathway entails withdrawing fluids over many hours till death, which has been reported much in the press, which can bring radical change to the patient who is often pumped with morphine at this stage to avoid any pain, which brings the patient to have breathing difficulties.

This can be natural but usually is the result of the dosing of morphine. This results in the patient having breathing difficulties, like my mother, who died of asphyxia after 36 hours of trying to catch her breath, and I have seen some 7 people die like this. They may not die in pain but certainly in discomfort.

The LCP though spells out a route of care that if followed does give a pathway that makes sure many caring ways are followed and which one would have hoped would be going on naturally, but within a busy ward often they are forgotten or simply young inexperienced doctors/nurses are not aware of.

So of course the LCP has many good points of good care for the potentially dying patient, so I do believe that as it is here within our hospital and being advised by all to follow, it is our duty to make sure that we do our best to get it used in the very best way and try hard to stop the practices that are not truly giving good care for the dying and their loved-ones.

As we only get one shot at death and the experience of our loved-ones death, so we HAVE to make sure it is the very best pathway to follow and we can start by changing its name to 'End of Life Care', which immediately tells one what it is about. I still though have reservations that to be put on to the LCP, tells the families and the medical team caring for a patient that a decision to die has been decided upon, which has to hold into question the Hippocratic Oath, as a patient can go from chatting happily with loved ones to being put on the LCP, to suddenly dying and hardly being able to breath, which has been my experience and has been much reported in the press. So it is not a pathway to just rubber stamp and to be used without due care and attention on every individual patient. We all have a right to die with the truly best care and, dare I suggest, love.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 18 July 2013

AGENDA ITEM NO.	2.14/Jul/13
PAPER	Embedding Trust Values – governors values/behaviours
AUTHOR	Carol Dale, Patient and Staff Experience Facilitator
LEAD	Carol Dale, Patient and Staff Experience Facilitator
EXECUTIVE SUMMARY	The paper attached presents values and behaviours expected from governors as discussed in workshops with governors earlier in the year and endorsed by the Council of Governors Quality Sub-Committee on 13 June 2013. It has been proposed that governors' values will be incorporated in the Council of Governors Code of Conduct.
DECISION/ ACTION	The Council of Governors is asked to agree the governors' values which will be subsequently incorporated in the Council of Governors Code of Conduct.

Embedding Trust Values

Trust Governors

How do we live these values as a governor?
Reporting concerns to the quality sub committee, engaging in ward visits, using the CQC standards on ward visits and rounds, reporting our own and others experiences at committees, observing hand hygiene policy, noticing and reporting any safety concerns.

How do we support the trust to live these values?
By co-ordinating our efforts and reporting to PALS who will receive and deal with patient or public concerns, being the eyes and ears of the patient, listening to staff and their experience.

How do we live these values as a governor?
Helping people find their way if we are in the trust, asking how staff they are and speaking respectfully in our communications with each other, good manners, listening in meet a Governor sessions, smiling and making eye contact, saying thank you to people we come into contact with.

How do we support the trust to live these values?
Noticing both kind and unkind behaviour and commenting on it, taking praise and positive comments back to the trust, being a champion to notice and comment on patient dignity, tell the public that kindness is important to the Trust, staff and patients, passing on good feedback and praise.

How do we live these values as a governor?
By making a contribution by attending meetings, contributing at meetings, supporting each other as team members, using our different skill sets and making best use of these, taking feedback from the Chairman as individual Governors.

How do we support the trust to live these values?
By being a champion of the Trust to the outside world, to act as an ambassador for the Trust, by expressing views and concerns on strategic direction, to declare any conflicts of interest, by advising people of the correct way to raise complaints or issues, by being available to support service improvement projects.

How do we live these values as a governor?
Need to lead by example in our own behaviours with each other by treating each other with respect in emails and at meetings, listening to others point of view, wearing our name badges while in the Trust, always introducing ourselves, being tactful and diplomatic.

How do we support the trust to live these values?
By building trust and respect between Governors and Executive and Non-executive Directors, by being disciplined in meetings regarding the agenda, support the trust to ensure responsibility and accountability and treating staff with courtesy

Choose Chelsea and Westminster

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 18 July 2013

AGENDA ITEM NO.	2.15/Jul/13
PAPER	Francis Inquiry Report update on progress
AUTHOR	Cathy Mooney, Director of Governance and Corporate Affairs
LEAD	Tony Pritchard, Acting Director of Nursing
EXECUTIVE SUMMARY	This summaries actions that have been taken and are in development to respond to the Francis Inquiry Report. The Council of Governors was advised at the meeting in May 2013 that as a result of the Francis Inquiry Report the Trust arranged listening events during April to June to listen to our frontline staff. The listening events were run by the Executive Directors initially and then by other managers in the organisation. Governors were invited to attend. Following the listening events, themes are being collated and linked back to the recommendations where appropriate. However, the recommendations are far reaching and affect all staff in the organisation including directors and governors and many aspects of care e.g. how we handle complaints, the need to be open and honest and the duty of candour. All the recommendations for provider organisations are being reviewed to plan how we address them and an action plan is in development. Some recommendations are being addressed nationally and some have already been considered e.g. being explicit about openness and honesty in the risk policy and revising the whistleblowing policy. The next steps are for the action plan to be presented to the Quality Committee and Trust Executive in August. A response detailing how the Trust is responding to the Francis Inquiry report and the action taken will be agreed by the Board of Directors and the Council of Governors in September. In the meantime work will be undertaken with the governors to reflect on their role changes as a result of the Francis Inquiry Report.
DECISION/ ACTION	For information

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 18 July 2013

AGENDA ITEM NO.	2.16/Jul/13
PAPER	Quality Awards Spring 2013
AUTHOR	Melanie van Limborgh, Head of Quality and Assurance
LEAD	Catherine Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	The Council of Governors' Quality Awards are awarded for Patient Safety, Patient Experience, Clinical Effectiveness and the Trust Values. For Spring 2013 there were 5 winners and 1 commendation. Following introductions by the relevant governors these awards will be presented by the Chairman during the July 2013 Council of Governors Meeting. (Further details of any of these awards are available from the Head of Quality and Assurance - Melanie.vanlimborgh@chelwest.nhs.uk)
DECISION/ ACTION	For the Council of Governors' to note for information and for a briefing prior to the presentation of winners at the July Council of Governors meeting.

Council of Governors' Quality Sub Committee Quality Awards Report
Spring 2013

1.0 Introduction

The aim of the Trust's Quality Award is to recognise and reward contributions to quality initiatives in the Trust from an individual or team who have made a contribution to quality for patients under four categories, (Patient Safety, Patient Experience and Clinical Effectiveness and the Trust Values). This award is open to Chelsea and Westminster Trust employees who all have the potential to directly or indirectly improve quality through improving the patient's experience. The award can be received for a project, an initiative, or a change in the work of staff that as a result provide benefit to quality of care.

As part of the award the winners have the opportunity to meet with key Directors and governors of the Council of Governors Quality Sub-Committee to discuss their initiatives and highlight their achievements. The winners also receive £250 to benefit the work of their department.

The Council of Governors Quality Awards are supported, directed and awarded by the governors from the Council of Governors Quality Sub-Committee. The Quality Awards are held twice yearly. Award applications are required to meet set criteria.

The Spring applications have seen sustained good numbers as on previous awards and there were 5 teams in the winning category and one commended application.

2.0 The Quality Award winners

2.1 Respiratory Physiotherapy - A review of service provision and implementation of simulation based on-call physiotherapy training.

The respiratory physiotherapy service is offered 24 hours a day, 7 days a week. The primary role of this service is to minimise and re-inflate areas of lung collapse, clear respiratory secretions and reduce the need for mechanical ventilation, hence escalation of care. The respiratory physiotherapy team (in collaboration with the centre for good clinical practice) led this work to enhance practice in the Trust.

Prior to this new initiative, the respiratory physiotherapy service had been provided by the specialist respiratory physiotherapy team split into a separate day and evening service. The evening was covered by on-call staff that was often non-specialist and worked in many different clinical areas across the hospital. Due to recent changes in the service provision across therapies, there was an increasing and unsustainable overlap between the end of a normal working day and the beginning of the evening on-call. The on call service was also not cost effective as the majority of call outs (50%) occurred between 4.30pm and 8pm in the evening.

In order to adapt to new hours of work across the therapies department; to reduce staffing costs; and ensure that patients are seen by specialist staff; the existing hours of service provision within the respiratory physiotherapy team was reviewed and amended. Additionally, the team also had to ensure clinical competence within the non-specialist workforce covering evening respiratory patients' on-call. This has previously been achieved through case study and lecture based annual training.

The project sought and established review and changes to the existing service provision with respiratory physiotherapy. A simulation training day aimed at improving clinical reasoning/ non-technical skills in the non-specialist work force was implemented in the physiotherapy team to provide and improved and enhanced service for patients.

2.2 Implementation of a men's health physiotherapy service for the treatment of incontinence post radical prostatectomy.

Best practice demonstrates that pre and post radical prostatectomy pelvic floor exercise training with a physiotherapist reduces incontinence rates post radical prostatectomy.
As part of this quality improvement, the women's health physiotherapy team changed practice to treat not only women with incontinence but also to increase their skills and to provide more care in the service to include treatment to men with specialist needs.

The multidisciplinary team (MDT) and their patients were questioned via a survey monkey audit of the service and how treatment should be reviewed. Work went forward with a specialist course and development of protocols in practise. The initiative in the new service met several effectiveness and patient experience goals for both male and female patients that included:

- Providing further treatment to improve the quality of life of patients following surgery and using evidence based care.
- Additional education for staff for treating incontinence - this resulted in a reduction in patients reporting in incontinence
- Meeting patients before surgery, planning patient centred care, explaining possible symptoms and supporting patients to help improve any symptoms if experienced.
- Assessments were developed to be patient centred and developing goals the patients wanted to achieve with individualised programmes
- Facilitating patients with pre-surgery exercises to help them to focus on their post-surgery requirements.
- Post-surgery follow up, support and familiarity with known experienced health professionals.

As a result, clinical consultants reported the new direction of care was considered 'essential to treatment' and the evidence from the survey undertaken demonstrated evidence of positive patient reports following treatment.

2.3 Implementation of the Nutritional Assessment Tool and National Care Pathway to improve Adult Patient Nutritional Care in an Inpatient setting

The Nutrition and Dietetic Department Acute Team of Dieticians and EPR team established the Nutritional Assessment Score (NAS), related nutritional care pathway, and electronic ward kitchen screens. There was support from several staff disciplines, volunteers and capital funding.

Over 5 years, audits identified inefficiencies in the Nutritional Assessment of patients. Formerly there was a stand-alone, paper-based process that was not integrated to the Electronic Patient Records, and not consistently benchmarked to national criteria. This meant time consuming Nutritional Assessment requiring audit and also when a patient moved within a ward or between wards, that the nutritional records regarding

patients'' requirements would have to be manually updated. This was costly in terms of hospital resources and often fell behind a patient's immediate nutritional requirements for the next day. The system was noted as unreliable, and not every case of potential malnutrition was being identified.

The National Patient Safety Agency (NPSA) and Care Quality Commission (CQC) identified patients' nutrition as a priority requiring all hospitals to have a process in place to prevent malnutrition from happening or worsening in patients. Patients have to be nutritionally screened for malnutrition on admission and weekly thereafter, to identify vulnerable patients allowing for systems to be put in place to support the nutritional care of that patient.

The objectives were to:

- Develop a system of screening embedded within the electronic admission process of the patient and weekly thereafter (paediatrics, maternity & ITU excluded)
- Consistently achieve 90% patients nutritionally assessed within 24 hours of admission
- Introduce weekly nutritional re-screening and achieve a target of 90% of patients re-screened
- Improve communication between all relevant parties (e.g. dieticians, nursing staff, catering staff and volunteer staff) by implementing an electronic identification system to keep staff constantly up to date with information.
- Acquire funding to support the delivery of electronic ward kitchen screens
- Ensure structures are in place to support best nutritional practices (Nutrition Pathway)

The project addressed quality in 2 phases and achieved:

- A more effective nutritional screening system was introduced in 2010, undertaken by nurse at the time of patient admission. The system moved from a paper-based system and the data was entered directly into a new system.

- In Phase 2 there was the implementation of an electronic communication system, aiming to improve the communication between all disciplines of staff on the nutritional care of all patients, especially those highlighted at risk of malnutrition. Dieticians worked with the EPR team (Electronic Patient Records) to agree how the nutritional care requirements could be integrated and accessed for each patient at the point of treatment.

Capital bids secured in 2012 funded screens within 10 selected adult wards. Since April 2013 these screens have been live in each selected adult ward kitchen, displaying up to date, and real time information on each patient's nutritional requirements. This has reported by the dietetic team to have enhanced the patient's experience of hospital, improved the patient's recovery and contributed to reducing the cost of patient care. The live information updates the Nutritional Care Plan and is clearly outlined for all at-risk patients. The overall initiative has raised the profile of nutritional care and ensures all disciplines are committed to positive improvements. The 90% target for initial screening is being achieved and the performance for re-screening is showing improvement every month.

2.4 Improving Medication Reconciliation at Discharge – Closing the Loop (M@D)

M@D project team led this initiative. Transitions between interfaces of care, especially discharge from acute hospital care into the community, are widely recognised as high-risk settings for the development of medicines-related problems (MRPs), and a leading cause of morbidity and mortality. 'Medication continuity errors' are reported as extremely frequent (involving up to 70% of patients) and have a major impact on rates of hospital readmission. Cost, to both patients and the NHS, is reported by the high by the DoH and the NPSA.

Local and national policies have raised the need for guidance for medication management at transfers of care (NICE/NPSA/CQUIN). Improving medication reconciliation (MR) throughout hospital stay is of strategic importance for both patient safety and financial measures.

The first project led by the team successfully improved MR on admission within the Acute Assessment Unit (AAU) at Chelsea and Westminster Hospital. After this the electronic prescribing (EPR) and electronic discharge summaries (DSUM) have become well established at the hospital. M@D has extended the improved process to discharge for all patients admitted acutely to AAU and subsequently discharged from any wards. The project was supported by the hospital and Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Northwest London.

This initiative increased patient safety, effectiveness and patient experience by:

- Reducing harm from MRPs due to incomplete/inaccurate information about medications at discharge
- Reducing the potential for re-admission due to preventable MRPs
- Ensuring clinical effectiveness of treatments by encouraging adherence through enhanced information provision
- Improving junior doctors' ability at completing changes to medications at discharge.
- Improving pharmacy staff contact with patient care through admission/discharge MR
- Expanding on tools available to nurses to counsel patients at discharge
- Improved documentation of changes to medications on the discharge summary

2.5 A model for responding to Domestic Abuse within a healthcare organisation - ensuring the safety of patients and protection of their information.

The Domestic Abuse team led on this work within the Trust and it has created a unique model of response to domestic abuse which could be adopted by other Trusts in the UK. The initiative included:

- Trust training in Domestic Abuse awareness and safe practice – on-going since 2010
- Enhanced training for high risk cases of domestic abuse and safety planning – for staff that have voluntarily become leads in their clinical areas and also Domestic Abuse Links (DALs.
- Training in routine enquiry for Domestic Abuse in Maternity services that has ensured a robust response by the team of midwives within a supported organisational framework, to protect the individual women; their unborn children and others who may be also be at risk of abuse.
- A confidential Social Information (CSI) Log that went live in April 2013 - the

development of a tool on LASTWORD to safely document sensitive disclosures. This information can now be held in a separate area of the electronic patient record and is available to view by clinicians only, and automatically sets up a discreet shared patient alert. This has improved appropriate sharing of information and maintaining patient confidentiality and respecting patient privacy. It is a tool that permits the recording of key multidisciplinary contacts for the patient within the Log – ensuring that all relevant information is recorded in one place. The tool also has the functionality to directly link staff into the Intranet folders on Domestic Abuse and Information Sharing guidance.

- Development of a Domestic Abuse referral pathway – to guide staff on best practice when a patient discloses domestic abuse. This will offer support to staff and a systematic approach with their patient management: Risk assessment/Clinical Care/ Safeguarding – it also includes how to document the disclosure, who to share information with, and how to protect the patient and others who may be at risk.
- Development of a Domestic Abuse folder on the Intranet – a key helpful resource available on the Intranet through the Safeguarding gateway, which contains useful required information.
- Development of a Safeguarding gateway icon on the Intranet homepage – a 'quick link' enabling all staff to access from a single point.
- Development of a Trust Domestic Abuse Policy – placing strategic managerial responsibility across the organisation to ensure that each clinical area has a nominated DAL and has the relevant resources available to support patients who disclose domestic abuse.

The team has received strong commissioning endorsement of their approach in this field and it is hoped by the team that when the Domestic Abuse Policy is given final approval in July 2013, it could become a model for other Trusts in Inner North West London to consider adopting. This could deliver a consistent approach within the sector for survivors of domestic abuse. The Trust's response to Domestic Abuse was due to be presented up as a model for others to consider at the British Association of Sexual Health and HIV's Sexual Violence training day in June 2013 at the Royal Society of Medicine.

3.0 The Commended Winner

The commended winner was the Acute Assessment Unit (AAU) Therapies Mapping and Service Improvement initiative. This was led by the inpatient therapy teams; Respiratory, Medical Rehabilitation and the Acute Assessment Team.

4.0 Summary

The Quality Awards led by the Council of Governors' Quality Sub-Committee are awarded for Patient Safety, Patient Experience, Clinical Effectiveness and the Trust Values. There were 5 winners and 1 commendation. Following introductions by the Quality Sub Committee Governors these awards will be presented by the Chairman during the July 2013 Council of Governors Meeting.

Further details of any of these awards are available from the Head of Quality and Assurance (Melanie.vanlimborgh@chelwest.nhs.uk)

Melanie van Limborgh
Head of Quality and Assurance, July 2013

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 18 July 2013

AGENDA ITEM NO.	2.17/Jul/13
PAPER	*Draft Minutes of the Council of Governors Quality Sub-Committee meeting held on 13 June
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Cathy Mooney, Acting Chair
EXECUTIVE SUMMARY	Draft minutes are enclosed.
ACTION	To note.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Quality Sub-Committee meeting, 13 June 2013

Draft Minutes

Attendees	Walter Balmford	WB	Patient Governor
	James Dennnis	JD	Staff Governor
	Martin Lewis	ML	Public Governor, Westminster 1
	Melvyn Jeremiah	MJ	Public Governor, Westminster 2
	Susan Maxwell	SM	Patient Governor
	Wendie McWatters	WMW	Patient Governor
	Sandra Smith-Gordon	SS-G	Public Governor – Kensington & Chelsea 2
	Cathy Mooney	CM	Director of Governance and Corporate Affairs
	Tony Pritchard	TP	Deputy Chief Nurse
	Melanie van Limborgh	MvL	Head of Quality and Assurance
	Holly Ashforth	HA	Nurse
	Patricia Gani	PG	Healthwatch representative
	Vida Djelic	VD	Foundation Trust Secretary
	Carol Dale	CD	Patient Experience Facilitator

1	**Welcome and Apologies**	**CM**
	Apologies were received from Sharon Connell, Therese Davies, Sian Nelson and Zoe Penn.	
2	**Minutes of previous meeting held on 19 March 2013**	**CM**
	Minutes of the previous meeting were accepted as a true and accurate record of previous meeting with the following amendments:	
	- p.1 attendees change for MJ ‘patient governor’ to ‘public governor, Westminster 2’ - p.1, item 3, re Discharge from A and E change ‘patents’ to ‘patients’ - p.2, re Quality Priorities change ‘Mayer’ to ‘Mayor’ - p.5, item 7, 4th para, first line change ‘staffed’ to ‘staff’	
	It was clarified that a patient and staff information resource to highlight the requirements to meet the Care Quality Commission (CQC) Essential Standards of Quality and Safety cannot be accessed by governors currently, but it will be part of the development to consider this being publicly available. SS-G queried a dedicated ‘easy and quick to read’ abridged version of the Quality Account discussed at the previous meeting. MvL responded that this work will be developed as part of an annual review document being produced by communications. CM confirmed that the quality account will be distributed to the members at the Annual Members’ Meeting in September.	
3	**Matters arising**	**CM**

	Discharge from A and E The sub-committee noted that A&E staff advise patients to seek post discharge support via their GP if required, however, staff are also able to refer to community nursing support and the Trust will ensure that all staff are fully aware of this. WMW suggested a poster being displayed presenting the information. TP responded that this requires further discussion and the decision on what information is most important. CM highlighted that the Trust is not assured that there is consistent knowledge between all staff on where and how to refer patients.	
4	**Complaints Report Q3 /complaints/minor concerns**	**TP**
	TP noted that the report provides a summary of the feedback and trends identified by the Complaints Team for Q3. He outlined the main points. The handling of complaints was outlined and noted that as a measure of good handing is how many complaints are re-opened and for the Trust it is 5%. Compared with the national level this is very good. JD asked how type 1 complaints are selected. TP responded that type 1 complaints are minor complaints and those which can be easily resolved and managed through PALS. The grading of concerns and complaints on p.3 in table 1 was outlined. The places that get the most of complaints are areas where patients are the sickest. There is more complexity therefore more room for complaints.	
5	**PALS Report Q3**	**TP**
	TP noted that the PALS report is produced on a quarterly basis and it mainly reports on concerns that can be easily resolved in the area where the concern occurred. A meeting with staff has been held to explore ways of enabling early resolution. It was noted that in Q3 PALS received 149 complaints and the top three concerns related to appointments (26%), communication (21%) and staff attitude (13%). Complaints were divided by divisions and directorates. TP outlined the plans for reorganising PALS. SM queried the difference in the number of complaints provided in the paper as opposed to the low number that come to the PEAT group. TP responded that the PEAT does not deal with all complaints and it receives relevant complaints only. On p.7 regarding the surgical directorate, it was noted that the large number probably related to appointments.	
6	**Quality Report commentaries**	**CM**
	CM thanked all stakeholders for providing commentaries on the Quality Account 2012/13.	

	It was explained that commentaries were replicated as in the Quality Account as received from each stakeholder and suggested actions had been inserted in red. It was noted that a quarterly report will be provided on progress with objectives. The comments from Healthwatch regarding formatting may be due to the word version received and further input will be sought after the published version is ready. It was suggested that discharge planning including medication is discussed at the next meeting and it should be put on the next sub-committee agenda. **VD to put discharge planning including medication on the next sub-committee agenda and invite a representative from the Discharge Transformation Group to attend.** TP noted that the patient survey results are published on the national patient survey website. He suggested that the quarterly patient experience report is made available to the public, possibly to be published on the transparency section of the Trust's website. **It was agreed to put slips, trips and falls and actions taken by the Trust to prevent harm on the next sub-committee agenda.** It was noted that clinical audits will be considered by Zoe Penn, Medical Director as part of clinical audit work. It was also noted that priorities for quality improvement 2012/13 and 2012/14 were outlined on p.6. On p.9 it was noted that commissioners had no particular issues to comment on. PG queried if anybody has read the Royal Brompton Hospital Quality Account. It was suggested that each governor read the Quality Account from another hospital. This was agreed. **Governors willing to volunteer to let MvL know.**	
	Viv Bell to be asked to comment on breastfeeding peer support and how this helps new mothers discharged as described in the quality account.	**CM**
7	**Quality Report 12/13 – feedback and next steps**	**MvL**
	MvL thanked all governors for their contributions to the Quality Account. The sub-committee noted that George Vasilopoulos is in the process of formatting and putting the text and pictures together for the Quality Account. As noted earlier in the meeting, an abridged version of the Quality Account will be part of a Trust annual report review and made available in August and distributed to members at the Annual Members' Meeting. A full quality account document will also be available. PG asked if more time can be allowed for commenting on a draft Quality Account next year. CM responded that that is possible but the earlier a	

	version is, the more draft it is and each stakeholder was asked for their deadlines and these were met. Foundation Trusts have a month less than non Foundation Trusts to produce their annual accounts as they are required to submit them to Monitor as part of the Annual Report. PG confirmed that no further information is required on complaints and concerns.	
8	**Quality Report 13/14 – forward look**	**MvL**
	MvL outlined the plans for the Quality Report 13/14. It was noted that themes identified from consulting staff on the content of the Quality Account will be presented at each sub-committee meeting so that there is an early indication of its content.	
9	**Quality Awards Spring 2013 - winners**	**MvL**
	MvL reported on a quality awards judging meeting which took place prior the sub-committee meeting. The sub-committee noted that the following winners: - Respiratory Physiotherapy Team - Women's and Men's Health Physiotherapy Team - Acute Team of Dieticians - M@D project team (pharmacy) - Domestic Abuse team It was noted that there was one highly commended applicant (AAU). It was highlighted that the information should be treated as confidential until the winners have been notified.	
10	**Embedding Trust Values – governors values/behaviours**	**CD**
	Carol Dale, Patient and Staff Experience Facilitator noted that governors' workshops were organised earlier in the year to discuss the Trust values and behaviours expected from governors and how governors can support the Trust in implementing the values as well as some practical examples of how to adhere to it. TP noted that it will be very important to sign up to the Trust values before undertaking clinical rounds. SS-G queried the progress with the rounds. TP responded that HR is in the process of doing CRB checks and once this has been completed Lead Nurses from the respective wards will contact governors to arrange dates for clinical rounds. The sub-committee discussed reporting of minor complaints/comments governors receive from hospital visitors and patients. It was confirmed that these should be passed to PALS to process providing the patients concerned have consented to it. An individual problem or common problem can be shared with the sub-committee under item 'feedback from governors on patient experience' but this sub-committee's remit is not to resolve individual complaints but rather to get a sense of the issues.	

	It was highlighted that some guidance is required in order to assist governors when receiving a complaint via meet a governor session.	
	It was agreed that CD will provide guidance in consultation with a few governors. SM, SS-G and WMW volunteered to assist.	**CD**
	CM highlighted that the governors' values will be agreed at the July Council of Governors meeting and subsequently incorporated in the Council of Governors Code of Conduct. WMW congratulated CD on the Trust values presentation provided at the Patient Experience conference on 12 June.	
11	**Quality Sub-Committee Terms of Reference**	**CM**
	CM proposed that the Quality Sub-Committee Terms of Reference review is postponed for the next six month due to change in organisational structure including the appointment of a Director of Nursing and Quality which will impact on the chairmanship of the sub-committee. **The sub-committee agreed that the review of the terms of reference is postponed for next six months.**	
12	**Quality Sub-Committee Membership**	**CM**
	CM noted that a lay member from the commissioners provided some good comments about the Trust's Quality Account and she proposed that this member is invited to attend the sub-committee meetings. **The sub-committee discussed and agreed the proposal.**	
	To invite the lay member from the commissioners group to the meeting	**CM**
	She also noted an interest from the local Borough in developing the Quality Account. The sub-committee were concerned about size and thought the most appropriate way of doing this should be considered.	
13	**Council of Governors funding report**	**VD**
	The sub-committee noted the report.	
14	**Feedback from governors on patient experience**	
	WMW reported on a patient who experienced difficulty with booking an endoscopy appointment. WMW reported on a maternity patient who experienced difficulty in being able to have her husband with her on the ward whilst waiting to deliver a baby. This was linked to preventing infections at the hospital. **TP to look into this.** WMW reported on a nursing mother whose baby was brought to Chelsea and Westminster from another hospital and the mother was put on a general maternity ward while her baby was on another ward and the mother was not allowed to breastfeed. She said that the issue was taken forward by the Medical Director. ML reported on a recent experience of A&E and suggested A&E	**TP**

	receptionist staff should be supported with training. SM reported on a positive experience she has recently had in the treatment centre. However she felt that day surgery needed some improvement. PG reported on her experience of an A&E receptionist when her mother was mistakenly referred to A&E whereas she should have been sent to the Acute Assessment Unit (AAU). SS-G noted that some of hospital floors require repairing.	
15	**Any other business**	
	None.	
16	**Date of next meeting – 12 September 2013**	

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 18 July 2013

AGENDA ITEM NO.	2.18/May/13
PAPER	*Draft Minutes of the Council of Governors Membership Sub-Committee meeting held on 2 July 2013
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Martin Lewis, Chairman
EXECUTIVE SUMMARY	Draft minutes are enclosed.
DECISION/ ACTION	For approval.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Membership Sub-Committee, 2 July 2013
Draft

Attendees	Martin Lewis	ML	Chairman
	Chris Birch	CB	Patient Governor
	James Dennis	JD	Staff Governor
	Melvyn Jeremiah	MJ	Public Governor
	Susan Maxwell	SM	Patient Governor
	Wendie McWatters	WMW	Patient Governor
	Maddy Than	MT	Staff Governor
	Steve Worrall	SW	Public Governor
In attendance	Katie Drummond-Dunn	KD-D	Communications Manager
	Layla Hawkins	LH	Head of Communications
	Sian Nelson	SN	Membership Manager
	Vida Djelic	VD	Foundation Trust Secretary
	Melanie.Christodoulou	MC	Helathwatch
	Priti Bhatt	PB	Equality and Diversity Manager

1 Welcome & Apologies **ML**

Apologies were received from Anna Hodson-Pressinger and Sam Culhane.

2 Minutes of previous meeting held on 16 May 2013 **ML**

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

- p.1 list of attendees, re MJ change ‘patient governor’ to ‘public governor’

3 Matters arising **ML**

CB commented on the format of response in outcome column of matters arising and suggested that more detailed information is enclosed where action completed. CB also queried the outcome of the Council of Governors election communication plan. VD responded that she would in future aim to provide more detailed outcome and detail this against each action and this would also need to be noted by each lead. VD noted that she organised two meetings for governors to meet prospective candidates. Idox Elections is currently in the process of collecting ballot papers returned from the members in the constituencies in which election take place on 4 July. VD also noted that at 23 May Council of Governors meeting it was agreed that due to an additional vacancy, which arose in May, the second highest polling candidate will be invited to fill in that seat and serve for a three-year term.

LH noted that broadly all actions have been completed. She suggested that an early plan is prepared for the next election and this will be discussed with the sub-committee at the next meeting. This will also be publicised at the September Annual Members’ Meeting. **VD to provide LH with the November elections date once confirmed with the Returning Officer. LH to prepare**

communication plan for the November elections.

4 Membership Development and Engagement Strategy 2013/14 KD-D/SN

SN outlined the strategy and highlighted that it focuses on the membership recruitment and engagement and communication with existing members. It was highlighted that recruitment of new members and developing representative membership is of particular importance. The emphasis has been put on increasing the number of BME members and other underrepresented groups. MC suggested that link can be established via Healthwatch.

The work on engaging with members continues via Open Day, Annual Members' Meeting, meet a governor sessions, medicine for members events, etc.

It was noted that the number of members increased by 410 in 2012/13.

MJ said that the body we had related to about BME recruitment (the BME Health Forum) was itself a federation of representatives of community groups. It was the help of those groups we really needed. There was a particularly lively one in the White City area and we might try relating directly to them.

JD felt that patients should be more targeted with regards to recruitment and when recruiting this group to look at diversity of patients in A&E and suggested that the membership application forms should be made available in waiting area.

SN noted that work with a Somali women's patient group earlier in the year was very successful and proposed this is repeated. Other opportunities include the Dean Street Clinic, the West London Centre for Sexual Health and the BME Health Forum.

JD suggested that some information could be published on the video screens in the hospital.

It was noted that one of medicine for members' events should be specifically designed to attract diverse patient members.

SW suggested that ratio community vs. patients is considered. MJ responded that it is circa 50/50.

MT noted that work experience and volunteering at C&W is very attractive to people and that they should be integrated in the Trust membership.

CB commented on section 1.1 re volunteers and that as matter of fact they are not members of the Trust and therefore this para should be removed. SN to update the strategy appropriately.

CB said it was not true that anyone who is a volunteer at the hospital can be a member of the Trust and suggested that the whole of section 1.1 'Who can be a member?' be deleted as all this was in our constitution and is not part of our strategy. CB also offered to send KD-D and SN a number of sub-editing suggestions.

5 Membership engagement and communication calendar of events **KD-D**

KD-D noted the programme of membership engagement and communications activity which are funded from the Council of Governors budget. The final date for the Medicine for members seminar in July is to be confirmed with Nick Hale and Natasha Booton.

It was also noted that date is to be confirmed for the Christmas at Chelsea and Westminster event.

Other engagement events for the reminder of the year were noted.

CB suggested that when we know the timetable for the November elections, we might want to slightly reschedule issues 7 and 8.

6 Membership recruitment – update **SN**

The sub-committee noted revised Q1 of 2013/14 membership report. There has been 392 new members (220 left) in Q1.

ML commented that C&W is doing well in relation to representing the community.

JD queried if C&W collects information relating to reasons for leaving the membership. SN responded that it is mainly due to moving address, leaving the country or if a person has deceased.

SN noted that the highest proportion of ethnicity is within the white category, and the lowest representation remains in the 'mixed' group.

SW queried how the socio economic grouping is calculated. SN responded that it is measured on post code. SN to forward to SW the explanation for calculation of socio economic grouping.

CB queried the time delay in his wife getting ballot paper in June after being switched from the public to the patient constituency in April. This was investigated by VD. Idox Elections confirmed that they did not get CB's wife data as a member of the patient constituency in the first cut of membership data. Capita confirmed that they are not at fault. CB said that it seemed to him that Capita was at fault. MJ suggested that the timeline for data cut is considered at the future elections.

WMW queried the delay in getting her ballot paper. VD responded that she requested that Idox Elections reissue Wendie with ballot paper next day delivery guarantee post. WMW confirmed that she has received ballot and queried why the one sent earlier in June was not received.

CB requested that SN and VD investigate both cases and produce a written report for the next Membership Sub-Committee meeting.

The sub-committee agreed that governors from the Membership Sub-committee

should be involved in renegotiation of contract when next due for renewal.

7 Annual Members Meeting – proposal **LH**

LH noted that the Annual Members' Meeting proposal paper will be presented to the July Board and the July Council of Governors.

She outlined the running order of the event.

CB asked that the sufficient time is allowed for Q&A. He also asked if more comfortable chairs could be provided.

It was noted that the Council of Governors would decide at the July meeting who would be doing the presentation and the Communications Team would support the chosen Governor in respect of helping pull together their presentation slides for the event.

8 Governors Stand at the Annual Members meeting **ML**

It was noted that there will be a governor's stand and the opportunity for members to meet governors.

ML suggested that the restaurant location is considered carefully considering the recent reorganisation of furniture and whether it would be suitable for this meeting. **LH to consider.**

9 Council of Governors Funding Report for the Membership Sub-Committee **VD**

This paper was noted.

MJ suggested that in section 1 of the report word 'recurring' is removed due to the fact that the budget figure is not the same every year. **This was agreed.**

10 Equality and Diversity

The sub-committee discussed the type of information the Trust collects from members via the membership application form and noted that C&W collects only information required by Monitor.

SW said that he is aware that some other trusts collect sexual orientation data from their members and he perceives this as way of being representative of the population. Some governors felt that if another type of information was to be collected from its members C&W would need to have justified reasons and explanation what it intends to use it for.

In response to a question from LH on Equality and Disability legislation, PB responded that there are nine protected characteristics; these are age, gender, ethnicity, disability, marriage, race, religion, sex and sexual orientation. LH felt that there is an assumption under Equality and Diversity legislation that all nine protected characteristics should be measured.

SN queried the purpose of collating this data. SW said that this would provide an indication of gay population involvement in the Trust. He said that the LGBT produce this data and he will forward it to SN/PB. The sub-committee was unclear how C&W will benchmark itself.

MJ expressed disagreement with collecting this type of information from members and he felt there was not justified purpose. He said that we need to know why we are collating it and what we will do with the information and felt that it could potentially be misused.

SM said that from recruitment experienced she knows that some patients mistakenly feel that data we collate will impact on the level of service they receive. She felt that if it were to be agreed to collate this data it should be clearly stated that it is optional.

CB felt that it might be good example to follow some other trusts which also collect this data from their members and agreed that it should be optional.

The sub-committee agreed that in principle it should be collected, notwithstanding the reservations which had been expressed.

PB noted that we can collect certain information providing we define the reasons for doing this and also to ensure that we comply with the data protection.
LH queried if there will be any cost implications from doing this. **SN to find out from Capita.**

PB proposed that this is discussed further outside the meeting and once the final agreement reached to come back to the Membership Sub-Committee. **The sub-committee agreed that this item will be discussed again at the next Membership Sub-Committee meeting.**

11 Any other business

WMW queried if any staff has responded to a patient who queried if the hydro pool was functioning. SN confirmed that PALS responded to the patient concerned.

SM noted that the staff membership is important to the sub-committees and that staff governors should be release from their duties to attend these meetings which are organised well in advance.

12 Date of next meeting – 24 September 2013

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 18 July 2013

AGENDA ITEM NO.	2.19/Jul/13
PAPER	*Membership Report Q1
AUTHOR	Sian Nelson, Membership and Engagement Manager
LEAD	Holly Ashforth, Acting Deputy Chief Nurse
EXECUTIVE SUMMARY	The paper outlines a current membership figures and plans for recruitment during 2013/14.
DECISION/ ACTION	The Council of Governors Membership Sub-Committee is asked to review.

1.0 Membership size and movements

Table 1 below shows the size and movement of membership for the year April 2012 to end of March 2013 by cumulative totals and by membership type.

Table 1. Size and movement of membership

OVERALL MEMBERSHIP OVERVIEW	Last Year 1 Apr 12 – 31 Mar 13	Next Year (Target)	Current Situation 30 June 13
As at start	**14,858**		**15,268**
New Members	1,811		392
Members leaving or changing constituency	1,401		222
TOTAL	**15,268**		**15,438**
PUBLIC MEMBERSHIP OVERVIEW	**Last Year 1 Apr 12 – 31 Mar 13**	**Next Year (Estimate)**	**Current Situation 30 June 13**
As at start	**5,942**		**5,850**
New Members	225		71
Members leaving or changing constituency	317		122
TOTAL	**5,850**		**5,799**
PATIENT MEMBERSHIP	**Last Year 1 Apr 12 – 31 Mar 13**	**Next Year (Estimate)**	**Current Situation 30 June 13**
As at start	**5,685**		**5,994**
New Members	573		320
Members leaving or changing constituency	264		95
TOTAL	**5,994**		**6,219**
STAFF MEMBERSHIP	**Last Year 1 Apr 12 – 31 Mar 13**	**Next Year (Estimate)**	**Current Situation 30 June 13**
As at start	**3,231**		**3,424**
New Members	1,013		1
Members leaving or changing constituency	820		5
TOTAL	**3,424**		**3,420**

2.0 Membership Joiners and Leavers January to April 2013

Between April and June 2013 – Quarter one (Q1), there were 392 new members and 222 members who left overall. This results in a surplus of 170 new members. Membership numbers are broken down (below) to reflect patient, public and staff membership representation.

2.1 Public Membership

Table 2 below shows public membership joiners and leaves between January and June 2013. From April to June 2013 (Q1), there were 71 members of the public who joined and 122 who left membership.

Month	Jan	Feb	March	April	May	June
Joiners	3	3	11	3	57	11
Leavers	3	3	7	104	7	11

Table 2. Public Membership joiners and leavers January to June 2013

2.2 Patient Membership

Table 3 below shows patient membership joiners and leavers between January 2013 and June 2013. From April to June 2013 (Q1), there were 320 patients who joined as members whilst 95 left patient membership.

Month	Jan	Feb	March	April	May	June
Joiners	2	2	1	7	298	15
Leavers	81	4	9	87	8	0

Table 3. Patient membership joiners and leavers January to April 2013

2.3. Staff Membership

Total staff membership at the end of Quarter one (Q1) is 3, 420.

3. Public Membership Ethnicity

Figure 1 shows public membership ethnicity. At the end of Quarter 1, 2013/14, the highest proportion of ethnicity is within the white category, and the lowest representation remains in the 'mixed' group.

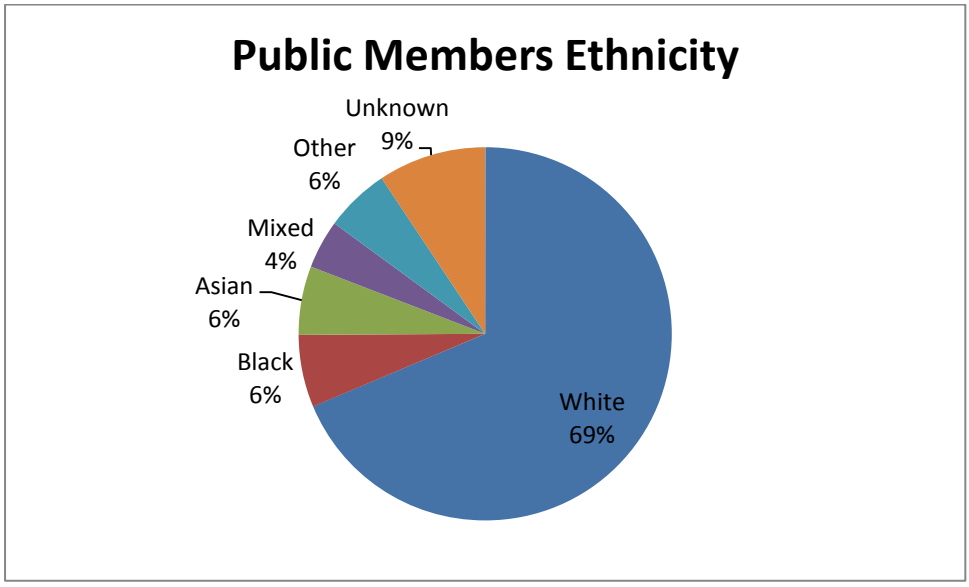
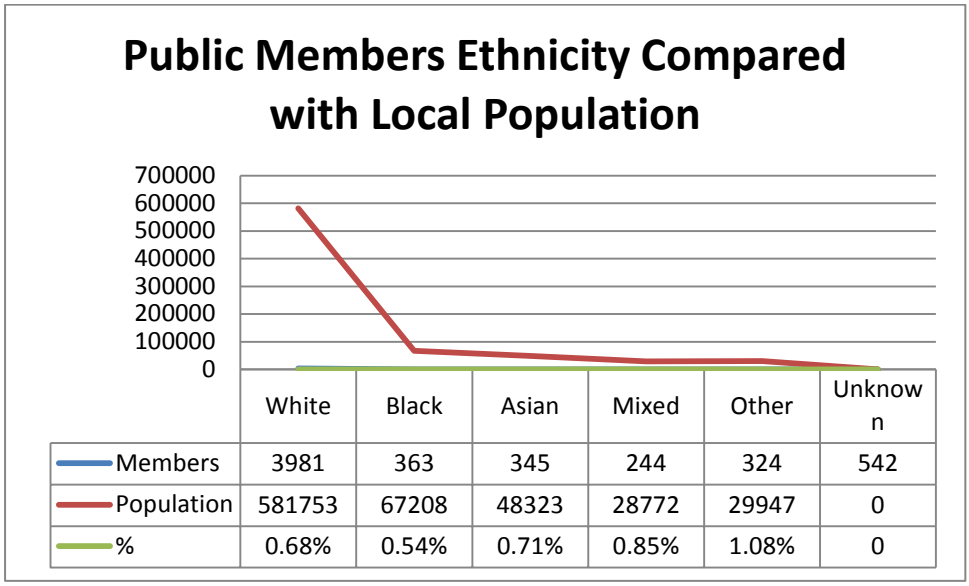


Figure 1. Public Membership Ethnicity end of June 2013 (Q1 2013/14)

3.1. Public Membership Ethnicity – comparison against local eligible population

Figure 2 shows the public membership comparison against the local eligible population. Here representation is highest in the Mixed population, followed by the Asian population and lowest in the Black population.



	White	Black	Asian	Mixed	Other	Unknown
Members	3981	363	345	244	324	542
Population	581753	67208	48323	28772	29947	0
%	0.68%	0.54%	0.71%	0.85%	1.08%	0

Figure 2. Public Membership Ethnicity - comparison against local eligible population. End of June 2013 (Q1 2013/14).

4.0 Public Membership Age

Figure 3 shows a profile of public membership by age. Public membership representation peaks at age group 40-49 years whereas the lowest age group is those within the 16-19 age group.

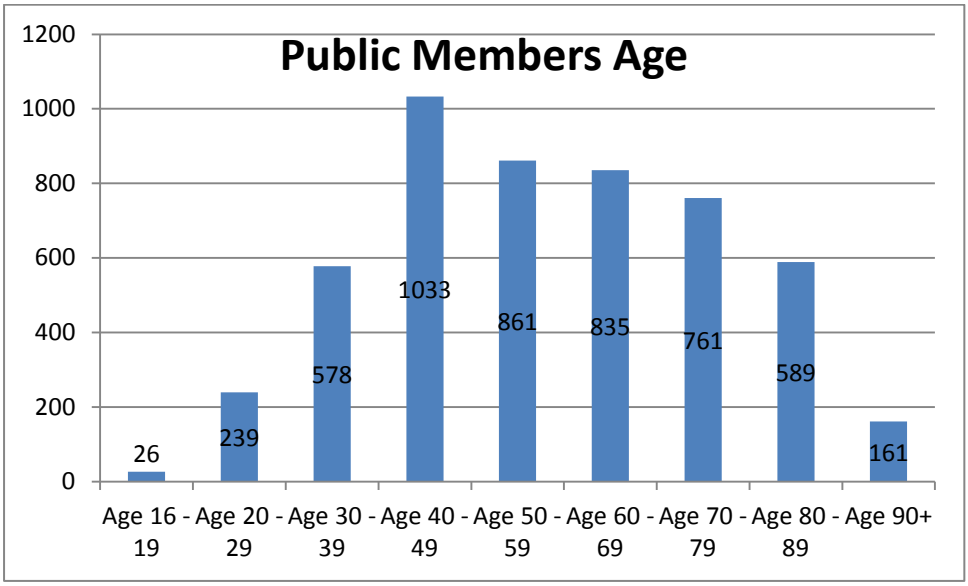
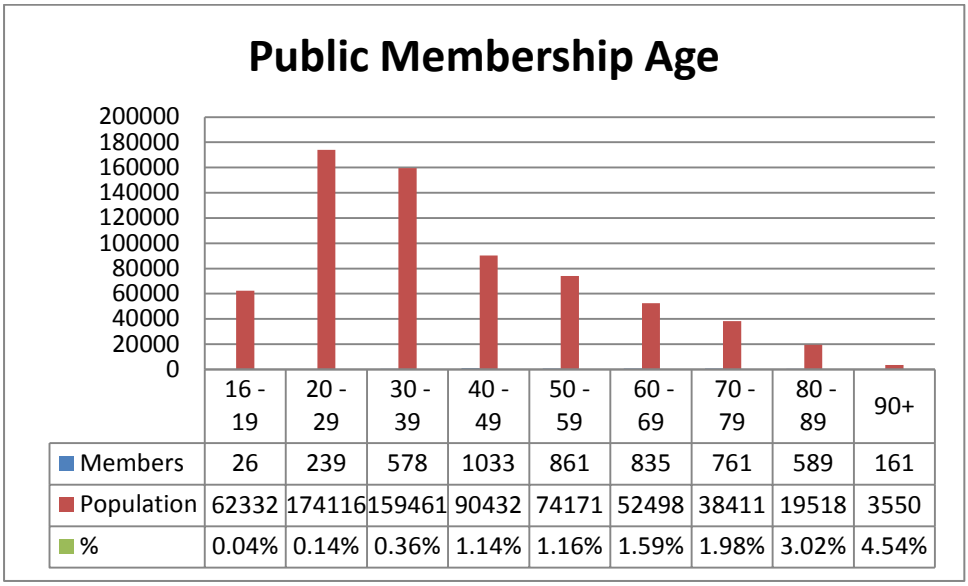


Figure 3. Public Membership Age

4.1 Public Membership Age – Comparison against local eligible population

Figure 4 shows the public membership profile in comparison to the local eligible population. The representation rises from 40 years and peaks in the 80-89 and 90+ year group.



	16 - 19	20 - 29	30 - 39	40 - 49	50 - 59	60 - 69	70 - 79	80 - 89	90+
Members	26	239	578	1033	861	835	761	589	161
Population	62332	174116	159461	90432	74171	52498	38411	19518	3550
%	0.04%	0.14%	0.36%	1.14%	1.16%	1.59%	1.98%	3.02%	4.54%

Figure 4. Public Membership Age – Comparison against local eligible population

5.0 Public Membership - Socio-economic grouping

Figure 5 below shows public membership by socio-economic groups. At end of June 2013 (Q1 2013/14) the highest representation remains in the ABC1 category* followed by category E*. There is no representation in the other categories.

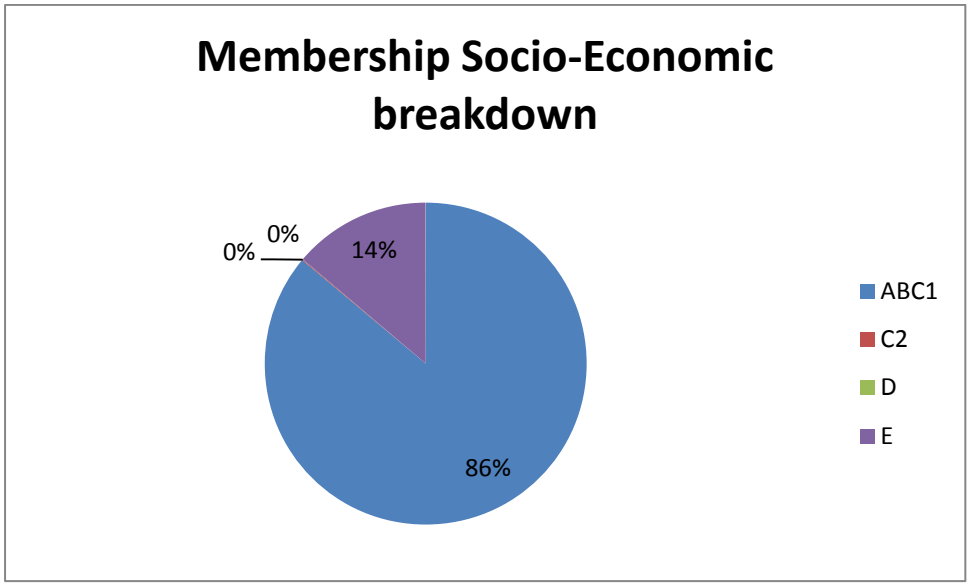


Figure 5 Public Membership - Socio-Economic Groups*

*Social economic grade: A-upper middle class (higher managerial, administrative or professional occupation, B-middle class (intermediate managerial, administrative or professional occupation), C1-lower middle class (supervisory or clerical, junior managerial, administrative or professional occupation), C2-skilled working class (skilled manual workers), D-working class (semi and unskilled manual workers) and E-those at the lowest level of sustenance (state pensioners or widows (no other earner), casual or lowest grade workers).

6.0 Membership Recruitment

During quarter one (Q1) 2013/14 there was a total of 392 new members and 222 members who left. This results in a surplus of 170 new members. This was achieved by a combination of recruitment activities from the Governors who recruited at Open Day and 'Meet a Governor' session and a recruitment campaign outsourced to Capita recruitment services.
A data cleanse is performed each quarter by Capita recruitment before member mailing which removes those not at the same address or who have been registered deceased. In addition Capita is notified monthly for requests of members' removal from the database

6.1. The Membership Development Sub-Committee of the Council of Governors develops and reviews the Membership recruitment strategy. Recruitment activity is focused on both maintaining our membership numbers whilst also enabling a diverse and representative membership.

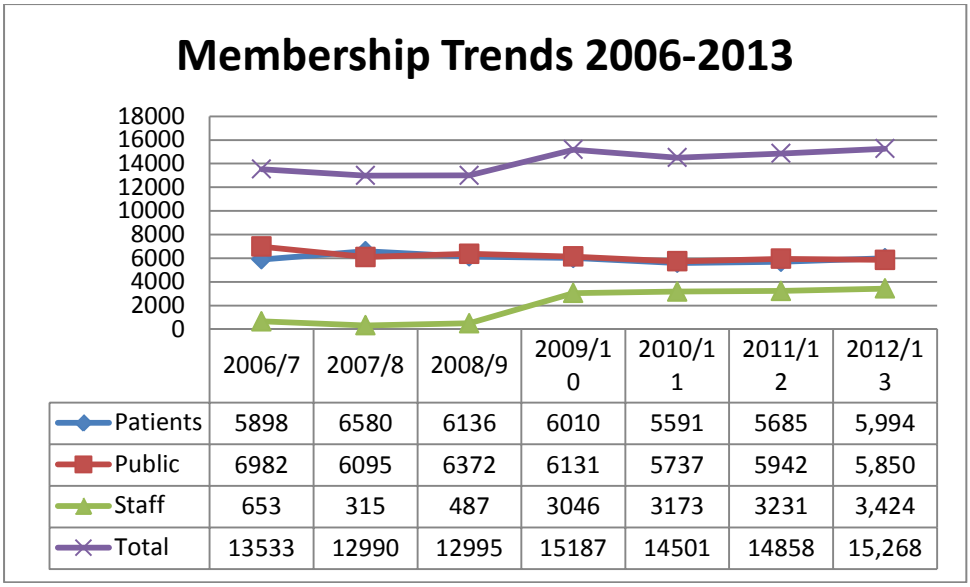
6.3. Governors continue to host 'Meet a Governor' session at the Ground floor Information Zone. Patients, public, staff and members have the opportunity to meet a Governor to discuss issues important to them. This is publicised on the Trust website, and a banner positioned at the hospital's main entrance.

6.4. The Patient Advice and Information Service support membership promotion. Visitors to the PALS office, when appropriate are offered a membership application form. Application forms are sent with patient response letters and the team will continue to actively promote membership.

6.5. The Communications team concentrate on Membership engagement and a plan for membership events has been agreed for 2013/14.

6.6. Membership recruitment campaigns are planned for 2013/14 – the first took place in May 2013, including Open Day and we exceeded the aim to recruit 300 new members (total 355). It is important to recruit throughout the year to ensure membership numbers are maintained. We aim to recruit 900 new members throughout 2013/14.

6.7. Figure 6 shows the trends in Trust membership from 2006-2013.



	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13
Patients	5898	6580	6136	6010	5591	5685	5,994
Public	6982	6095	6372	6131	5737	5942	5,850
Staff	653	315	487	3046	3173	3231	3,424
Total	13533	12990	12995	15187	14501	14858	15,268

Figure 6. Membership trends 2006-2013

7. Recruitment Campaigns

7.1. Recruitment campaigns are scheduled for four times throughout 2013 with an aim of 900 new members to counteract those members that leave membership.

7.2. The first event completed was week of May 7th – this included Open Day on 11th May 2013. The recruitment event aimed to gain 300 new members, promote Open Day and the Governor Elections.

8.0 Developing a Representative Membership

8.1. Analysis of the membership database by age, gender and ethnicity ensures we work towards representative memberships within the communities we serve.

8.2. To create equal representation, It is recognised that membership recruitment should focus on recruitment and engagement with Black, Ethnic and Minority groups. Our recruitment strategy will continue to focus on activities which can encourage wider representation within our membership.

8.3. Table 3.1 highlights that although trust membership figures are higher in the white category; ethnic groups are more balanced when compared to the local eligible population.

8.4. We will now explore further options to recruit from local community groups as a part of our strategy to develop a representative membership. All membership engagement activities during 2013 will be promoted to local BME groups.

9.0 Summary

9.1. The hospital gained Foundation Trust status in 2006 and at year end 2006/07 totalled 13, 533 members. Membership numbers peaked in 2009 when staff members' status changed from 'opt in' to 'opt out'.

9.2. We need to continue our focus on recruitment to maintain our membership numbers whilst also seeking a representative membership. Beyond this, we have introduced initiatives such as 'Medicine for members' to actively encourage the engagement of members in the work of our hospital.

10. Membership Recruitment 2013/14

The below table summarises key recruitment events scheduled for 2013/14

Month	Event	Total Recruited	Report	Funds Approved
May 2013	Members Recruitment Campaign Promotion for Open Day May 2013 And Governor Elections	300 members Achieved	Q1 2013/14	£2,340
September 2013	Members Recruitment Campaign and promotion of the Annual Members Meeting (within the hospital)	Aim – 150 members	Q2 2013/14	£1170
October 2013	Members Recruitment Campaign and promotion of Governor Elections (Inc. within the community)	Aim – 150 members	Q3 2013/14	£1170
TBC	Aim - 300 members Focus on BME groups		Q4 2013/14	£2, 340

Council of Governors Meeting, 18 July 2013

AGENDA ITEM NO.	2.20/Jul/13
PAPER	*Open Day 2013 evaluation report
AUTHOR	Katie Drummond-Dunn, Communications Manager
LEAD	Layla Hawkins, Head of Communications and Marketing
PURPOSE	This paper provides a summary and evaluation of Open Day 2013
EXECUTIVE SUMMARY	The Council of Governors provided funding for Open Day 2013 which was held on Saturday 11 May from 11am-3pm. More than 2,000 visitors came to the event—and 107 new members were recruited. This evaluation report summarises the main activities which took place during the Open Day and outlines the feedback gathered by volunteers throughout the day. The report also makes recommendations for Open Day 2014 to be discussed by the Council of Governors including a request for funding to support next year's event.
DECISION/ ACTION	The Council of Governors is invited to comment on the paper and to approve a request for funding of £20,000 for Open Day 2014.

Open Day 2012 – Evaluation Report

1.0 Introduction

1.1 Open Day 2013 was held from 11am—3pm on Saturday 11 May and was once again supported financially by the Council of Governors.

1.2 It was an opportunity for the Trust to place itself at the heart of its community by opening its doors to local people and giving them a chance to become more involved in their local hospital.

1.3 2,049 visitors came to the event which was officially opened by actress Maureen Lipman CBE.

2. Aims

2.1 Broad aims of Open Day 2013 were to:

- Promote the achievements of the hospital
- Celebrate the Trust's 20th anniversary
- Encourage Open Day visitors to become Foundation Trust members
- Develop communication between Council of Governor's representatives and Foundation Trust members
- Promote health, fitness and wellbeing
- Showcase developments at the hospital
- Foster partnership working
- Improve staff morale
- Market the Trust to current and potential Foundation Trust members and local residents
- Utilise the day as a fundraising opportunity for the Chelsea and Westminster Health Charity and other associated charities

3.0 Planning and implementation

3.1 An Open Day Operational Group was formed to plan and manage the implementation of the event.

3.2 The Operational Group was jointly chaired by Therese Davis (Chief Nurse and Director of Patient Experience and Patient Flow) and Helen Elkington (Head of Estates) and included senior representatives from many of the hospital's services and departments. Susan Maxwell (Patient Governor) and Wendie McWatters (Patient Governor) represented the Council of Governors at the meetings.

3.2 The Communications Manager was responsible for project managing the Open Day including publicity, logistics, liaison with Trust teams, charities and partner organisations that took part in the Open Day.

4.0 Key events and highlights

4.1 Actress Maureen Lipman CBE officially opened the event thanks to an invitation through Governor Wendie McWatters. Local dignatories who attended the Open Day included Cllr Buckmaster and Mrs Anne Hobson, Mayor and Mayoress of Kensington and Chelsea, Cllr Nicola Nardelli, Deputy Mayor of Wandsworth and Tom Hayhoe, Chairman of West Middlesex Hospital.

4.2 The Trust's 20th anniversary celebrations started at 2013 Open Day. Staff wore emerald coloured t-shirts with the 20th anniversary logo which had been especially designed by George Vasilopoulos. The balloons and other supporting materials were also printed with the logo. The 20th anniversary stand had a timeline marking all the significant events from the last 20 years and a birthday card, which visitors signed.

4.3 A Careers Event organised by Maddy Than (Volunteer Services and Work Experience Manager) encouraged young people to attend and learn about the different careers available in the NHS. Many staff supported this event taking part in an information session about their profession.

4.4 The 'Health and Wellbeing Zone' located in the Lower Ground Floor Outpatients Department was a popular area. Visitors were able to ask for health advice or have general health checks including height, weight, blood and pressure.

4.5 Pre-event publicity included:

- Membership mailing to all Foundation Trust members in April including a covering letter from the Chairman and a copy of *Trust News*
- Information on the Trust website including a prominent advertisement on the home page
- A prominent banner at the front of the hospital
- Flyers and posters distributed widely in the local community teams involved in the Open Day and Governors – thank you to all Governors who helped with the distribution
- Targeted mailings to schools in the local community about the Open Day
- Targeted mailings to schools and colleges about the Careers Event carried out by Maddy Than
- Advertising in the three local newspapers—*Fulham and Hammersmith Chronicle, Kensington and Chelsea Chronicle and Westminster Chronicle*
- A '*Fulham Chronicle* website advert
- A letterbox leaflet drop to residences located nearest to the hospital

4.6 Post-event publicity included:

- Photo gallery on Trust website
- A film of the day which can also be used in next year's advertising campaign
- Photo gallery in June/July issue of *Trust News*
- Editorial coverage in local newspapers

5.0 Evaluation and feedback

5.1 More than 2,000 visitors attended the Open Day

5.2 Volunteers encouraged visitors to fill in feedback forms (see Appendix 1 for full results):

- 98% rated the Open Day as 'Excellent' or 'Good'
- 98% would definitely recommend the Open Day to friends and family
- 98% said staff at the Open Day were friendly and approachable

5.3 Governors recruited 107 new Foundation Trust members during the Open Day.

5.4 A couple of other Trusts have approached the Communications team to find out about how we organise the Open Day, as they have heard it was a success.

5.4 The Careers Event was attended by approximately 200 people.

6.0 Budget

6.1 The Council of Governors kindly provided £20,000 for the 2013 Open Day.

6.2 The table below provides a breakdown of costs:

Item	**Cost (£)**
Entertainment	1,450.00
Facepainter	200.00
Photographer	180.00
Printing – flyers, posters, programme	1,262.40
Furniture Hire	2,343.06
Balloons	1,009.20
T-shirts	1,932.00
Camera equipment	2160.00
Petty cash for stands	975.00
ISS (bottled water, fresh fruit for stands, function etc.)	2908.08
Refreshment vouchers	1,335.76
Best stand prize money	175.00
Advertising	1087.44
Leaflet drop	2948.40
Flowers	130.00
Total	**20,096.34**

7.0 Open Day 2014

7.1 Subject to agreement and the availability of key members of the Executive team and the Council of Governors, it is proposed that Open Day 2014 will be held in June. This is to avoid clashing with exam timetables for students attending the careers event and running the Teddy Bear Hospital. Pushing the date back would also help the Communications team manage two high profile events (the Star Awards take place at the end of April).

7.2 The Trust is very grateful for the financial support provided by the Council of Governors for previous Open Days and we would like to ask the Council to consider funding of £20,000 for Open Day 2014.

Katie Drummond-Dunn
Communications Manager
July 2013

Appendix 1: Open Day feedback

Number of respondents:
2013 39 paper 6 iPad
2012 102 responses
2011 178 responses (using Patient Experience Tracker)
2010 136 responses (using Patient Experience Tracker)

2009 127 responses

1. How would you rate the Open Day?

	2013	2012	2011	2010	2009
Excellent	76%	83%	87%	77%	71%
Good	22%	17%	12%	20%	28%
Fair	2%	0%	1%	3%	1%

2. Did you find the stands informative?

	2013	2012	2011	2010	2009
Yes, definitely	78%	92%	85%	77%	86%
Yes, a little	15%	7%	15%	21%	13%
Not really	7%	1%	0%	0%	0%
No	0%	0%	0%	2%	1%

3. Were the staff friendly and approachable?

	2013	2012	2011	2010	2009
Yes, definitely	94%	95%	94%	93%	88%
Yes, a little	4%	5%	6%	6%	11%
No	2%	0%	0%	1%	1%

4. Would you recommend the Open Day to friends and family?

	2013	2012	2011	2010	2009
Yes, definitely	96%	96%	92%	86%	88%
Maybe	2%	4%	8%	12%	10%
No	2%	0%	0%	2%	2%

5. Did you find everything you were looking for?

	2013	2012	2011	2010	2009
Yes, definitely	71%	75%	71%	77%	70%
Sometimes	29%	25%	26%	21%	28%
Seldom	0%	0%	2%	1%	1%
Never	0%	0%	1%	1%	2%

6. How did you hear about Open Day?

	2013	2012
Posters and promotion throughout the hospital	27%	10%
Newspaper advertisement	7%	5%
Chelsea and Westminster Hospital website	7%	11%
I received a postcard through my letterbox	11%	10%
I happened to be walking past the hospital today	7%	14%
Other (see below for details)	42% **	50% *

* Responses to this question included having a friend or family member who works at the Trust, through their school, the visitor was a member of the Foundation Trust who received an email or membership mailing, the person had an appointment in the hospital on the day or was visiting a patient, or they had heard about it through the Trust's Twitter feed

** Responses to this question included through their school, from a member of staff, they come every year, through Foundation Trust member information (Trust News mailing/Members' e-News), they volunteer at the hospital, via a friend, via the Social Mobility Foundation

Extra question for 2013: Which was your favourite type of stand?

	2013
Fun and games	14%
Tests and quizzes	10%
Information and health advice	60%
Interactive	16%

FTGA

11

Essential Brief
June 13

Significant transactions: a guide

Foundation Trust
Governors' Association

Debate | Exchange | Learn

These Essential Briefs have been researched and written especially for foundation trust governors. They provide governors with the essential information they need to fulfil their roles. To see the full range of titles in the series, visit www.ftga.org.uk

Background

The Health and Social Care Act 2012 (the Act) gave foundation trust governors a set of new responsibilities for how their foundation trusts are run. As of April 1 2013 a foundation trust requires governors' approval before it can proceed with a "significant transaction". This Essential Brief explores this new responsibility and gives practical guidance to equip you to understand and evaluate significant transactions in your foundation trust.

In the context of the Act a "significant transaction" is not defined, but it is understood to mean a contract or an arrangement that changes the size or nature of the foundation trust and may include things like capital investment or taking part in a joint venture. A significant transaction could involve taking on new and different services, such as when many acute or mental health foundation trusts took over the management of community services in recent years.

It is, however, the potential for transactions to change a foundation trust that explains the role of the governors and the need for all foundation trusts to agree a local definition of what constitutes a significant transaction.

This Essential Brief suggests that "significance" should be judged by whether a transaction might change an existing foundation trust to an extent that governors should have a say over the proposed change before it takes place. This is because change creates risks as well as opportunities in large and complex organisations.

The governor's new role in approving proposed significant transactions is part of a broader set of governance requirements and controls that aim to ensure that major change is not undertaken without appropriate oversight of benefits and risks.

What happened before the Health and Social Care Act?

Monitor's definition of significant transactions prior to the Act was based on the Stock Exchange's requirement that listed companies obtain shareholder approval for large transactions involving more than a 25% change in turnover, net assets or capital.

Under Monitor's *Compliance Framework*, it issued indicative risk ratings for significant transactions, but it did not formally grant approval.

What checks and balances does the Act introduce?

The Act calls on governors to perform oversight of significant transactions due to the potential impact on patients, commissioners and staff. The key changes in the Act are:

- More than 50% of governors voting at the relevant meeting are needed to approve a significant transaction (section 167 of the Act);
- A foundation trust can define a "significant transaction" in its constitution.

Defining significant transactions in foundation trust constitutions

The Act gives foundation trusts an option to define significant transactions in their constitutions.

This definition might cover transactions such as acquiring part of another organisation, entering into a joint venture, or making a large capital investment. One advantage of defining significant transactions in advance is that it is clear when governors' approval will be required.

The FTGA recommends as good practice that foundation trusts define significant transactions in their constitutions[1]. We suggest that this definition is considered by a governance sub-committee or

1 Amendments to the trust's constitution must be approved by the council of governors. Approval means more than half of the governors voting agree with the amendments. Amendments no longer need to be submitted to Monitor for approval.

at a governors' away day in consultation with the foundation trust's executive officers and the board.

If a foundation trust chooses not to have a definition, governors retain the responsibility to approve mergers with, and acquisitions of, other whole foundation trusts or NHS Trusts as well as the separation and dissolution of foundation trusts.

Monitor has not provided guidance in its revised Model Core Constitution on how foundation trusts should define significant transactions. When considering a definition, consider the following issues:

1. **What is going to be defined as a significant transaction?**
   The acquisition of part of another trust, for example a whole speciality, is likely to be considered significant as would a disposal on a similar scale. Other changes with a big impact such as capital investments and internal service reorganisations could be defined as significant. Capital investments were defined by Monitor as significant transactions in the *Compliance Framework*, but were not cited as an example of organisational change by the Department of Health when it drafted the Act. Major internal service change, for example reconfiguring services from several sites onto one, was not envisaged by either Monitor or the Department as being a significant transaction, but could be in your foundation trust.

2. **What criteria are going to be used to judge "significance"?**
   Monitor used turnover[2], net assets[3] and capital[4] as financial criteria. These are established metrics, but there are potential loopholes. A transaction involving considerable assets and liabilities could have a low net asset impact, but actually represent significant risk. Using the value of just the assets, before netting off the liabilities, as an additional criterion might be appropriate.

2 Definition – The amount of money a foundation trust gets from contracts and other transactions during the course of a financial year.
3 Definition – All of a foundation trust's assets minus its liabilities
4 Definition – The amount of buildings, cash and other physical assets owned by a foundation trust.

Governors should also consider if the criteria should be purely financial as previously used by Monitor. Clinical criteria could be included, using, for example, the expected change in the numbers or types of patients treated before and after a proposed transaction. Such criteria would catch changes involving a large number of extra patients but bringing relatively little new income, for example patients seen in a community setting.

Possible operational criteria might include the expected change in the overall number of staff employed. Any criteria selected should be judged against the expected full effects of the transaction, which might be several years after the date on which it takes place.

3. **Will thresholds be set against each criterion to determine significance?**
   There is probably an advantage in setting numerical thresholds against each criterion chosen. Numerical thresholds are usually easier to apply than other more subjective approaches and limit the potential for misunderstanding of the rules, but strict numerical thresholds also limit the ability of a foundation trust to apply its own rules flexibly in different situations. Some criteria could, however, be absolute, for example any change triggering a public consultation could be deemed significant.

4. **What is an appropriate threshold to determine significance?**
   Many governors who have looked at this issue have concluded that Monitor's 25% threshold is too high, since most foundation trusts make small surpluses and a transaction representing only 10% of income could still easily push a foundation trust into deficit. If a foundation trust chooses to use clinical or operational criteria there is no precedent from Monitor to use as a starting point. For simplicity, it might be best to pick the same threshold for financial and non-financial criteria. With very little data to go on it would be difficult to meaningfully vary the threshold across different metrics e.g. does the transaction affect 10% of patients?

As an exercise, consider the annual budget of your foundation trust. Twenty-five per cent for a foundation trust with an annual budget of £200m would mean governors being asked to consider only transactions of more than £50m. What would that threshold have precluded governors from approving in the past?

5. Can the thresholds be set to allow for some flexibility?

Not all transactions of the same size represent the same degree of change or risk. For example, taking on similar services probably involves less risk than acquiring very different services that management may not understand. Also acquiring services that are some distance away may make it more difficult for management to control the new services. It might be appropriate to set higher thresholds for the expansion of existing services or those near existing locations than for new services or expansion into new geographical areas.

There is information about what some foundation trusts have done on the FTGA website. There are no right or wrong approaches to this issue, but over time good practice is likely to emerge. If your foundation trust has never undertaken a significant transaction it would be a good idea to speak to governors at one that has before finalising your local rules.

Governors' role when significant transactions are proposed

When during the process should approval be given?

This is not prescribed, but it should be BEFORE the transaction has taken place and before a legally binding agreement to proceed has been signed. Since governors are likely to expect a proposed transaction to be recommended by the board of directors, governors' approval should probably take place AFTER the board of directors has given its approval. Some small areas might not be finalised and it is reasonable to grant an individual or the board discretion to resolve specific outstanding items, but it is probably not a good idea to give final approval before most of the details have been agreed or before the board of directors feels there is enough certainty for it to give approval. In any event, final approval will be smoother if governors are briefed early in the process and given a chance to voice concerns before the closing stages.

What should governors do before granting approval?

There are a number of questions that governors might ask the board before granting approval:

- Is there a clear strategy for the transaction? Does that strategy fit in with what governors have previously agreed with the board is the long-term strategy of the foundation trust?
- Can the board explain and quantify the clinical or financial benefits? Boards should be able to be quite specific in this area and be able to point to evidence to support the proposed benefits.
- Has due consideration be given to clinical opinion of your own doctors and nurses? Have they been asked? What is their view? Where there is doubt, governors should ask to hear directly from the medical director. Remember, governors can call an executive to a council meeting under the Act.

- Can the board explain the risks, and what it has done to mitigate them? Boards should demonstrate that they have gone beyond the exercise of compiling a risk register. Consider asking how plans for the proposed transaction have changed after the board evaluated the associated risks as a way of ensuring that risk management has made a difference. There should be a business case, a long-term financial model and a benefits case – financial and clinical – for governors to see or be briefed on. In addition, can the board explain what happens if the transaction does not proceed? What are the consequences of refusal?

- Has the board received independent financial assurance? The most valuable assurance comes in the form of a signed "opinion" from a major accounting firm on a working capital statement. This is a report to the board that the accountants are reasonably certain that the trust will not run out of cash for at least a year after the transaction even if things do not go according to plan.

- Has the board received independent clinical assurance? It is unlikely that a written opinion can be obtained in this area. However, some consulting firms employ clinicians who will report on any clinical risks created by the transaction. Advice may also be available from the relevant Royal College or another national body.

- Has the board considered the views of commissioners and other key stakeholders? It is highly unlikely that a board would propose a transaction without at least asking key local stakeholders such as Clinical Commissioning Groups (CCGs) and local authorities, but it is worth understanding if these stakeholders have any serious concerns.

- Has the board got a clear plan for how it will complete the transaction and deliver the expected benefits? Most transactions that fail to deliver the expected benefits fail because the plan was weak or poorly implemented. The board should have a detailed post-transaction implementation plan. Monitor sometimes insisted on an external report on the robustness of a board's transaction planning.
- Has due consideration been given to the interests and views of members and the public? Significant change in the NHS is often controversial and foundation trusts may have to lead rather than follow public opinion. In all cases boards should have started public engagement and have considered the results of that engagement before transactions reach the governors.

This is not an exhaustive list. Many of the questions governors might ask of the annual forward plan can also be asked of a proposed transaction. Governors should also be mindful that their role in this area is new for most board members. The standard advice to act as a "critical friend" is highly applicable, but boards should be able to answer constructive questions. If they cannot, governors could consider asking the board to delay the transaction while their concerns are addressed.

What can we learn from NHS and private sector experience of significant transactions?

There have been relatively few significant transactions considering that foundation trusts have been in existence since 2004. There appear to have been only four full-scale acquisitions of NHS trusts by foundation trusts, though a large number of foundation trusts have taken over community services. There have also been a small number of capital investment transactions that Monitor considered significant.

From the significant transactions that have taken place a few broad themes emerge:

- Such transactions are complex and they may demand skills that some boards do not have.
- They are time-consuming because of their complexity and because various external approvals and reviews are required, for example by Monitor. It can take over year from the first proposal of a transaction to it actually taking place.
- It generally takes much longer, and is much harder to integrate newly acquired services into the foundation trust than management originally expected. That is not a sign of failure, but is a reality that should be planned for.
- Transactions can be expensive. A full-blown acquisition of another trust could cost over a £1m in fees and expenses. That is money not being spent on frontline services – this is not a reason not to proceed, but does justify scrutiny of the strategy and expected patient benefits.
- Management teams have limited capacity. Foundation trusts with pre-existing problems probably do not have the ability to improve their existing services at the same time as planning and delivering a significant transaction.

A study by management consultants McKinsey of hospital mergers in the UK, France, Germany, Norway and the US found that few of the mergers they studied delivered the promised benefits. A separate study of 112 UK hospital mergers between 1997 and 2006 found that none enhanced care quality. At most of the hospitals clinical productivity remained unchanged and financial performance deteriorated. Monitor has also published lessons learned from some previous transactions.

By way of comparison, in the private sector most mergers and acquisitions fail to deliver their objectives. Many actually leave companies worse off.

Closing thoughts

What can governors learn from all this? In the case of significant transactions, the critical friend is probably also a sceptical friend. The evidence that significant transactions are risky is too overwhelming to start from a completely neutral perspective. However, if boards can address questions such as those set out above then governors should place due weight on such reassurance. The Department of Health expects many NHS trusts to be acquired by existing foundation trusts and most NHS leaders believe that widespread reconfiguration of services is needed to deliver the best outcomes for patients and to keep the NHS affordable. These objectives will not be delivered if governors take an overly sceptical approach or if they reject proposed transactions rather than using their new responsibilities to engage with boards to strengthen the proposals.

Further information

- Monitor's *Compliance Framework*. Revised annually until the introduction of the provider licence.
- The *Provider Licence* once approved by the Secretary of State and Monitor's Risk Assessment Framework.
- *The Principles and Rules for Co-operation and Competition in the NHS.*
- *Marry in haste, repent at leisure: when do hospital mergers make strategic sense* (McKinsey, 2012).
- The FTGA website (www.ftga.org.uk) also includes additional resources and discussion forums about significant transactions and other topics.

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