Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Council of Governors Meeting

Hospital Boardroom
**Chair:** Prof. Sir Christopher Edwards
**Date: 3 December 2009**
**Time: 4.30pm**

# Agenda

'Starred' items will not be discussed unless an advance request is made to the Chairman.

| | | Lead | Time |
|---|---|---|---|
| **1** | **GENERAL BUSINESS** | | |
| 1.1 | Welcome & Apologies | CE | 4.30 |
| 1.2 | Announcement of results of elections | CE | 4.33 |
| 1.3 | Code of Conduct Acceptance (attached) | CE | 4.35 |
| 1.4 | Declaration of Interests | CE | 4.40 |
| **2** | **FOCUS ON QUALITY** | | |
| 2.1 | What is Quality? - presentation | CM/MA/AMC | 4.40 |
| 2.2 | Registration with the Care Quality Commission (oral) | CM | 5.00 |
| 2.3 | The assessment of quality (patient experience) – to follow | AMC | 5.10 |
| 2.4 | Quality sub-committee (attached) | CM | 5.20 |
| **3** | **PREVIOUS MEETING** | | |
| 3.1 | Minutes of Previous Meeting held on 17 September 2009 (attached) | CE | 5.30 |
| 3.2 | Matters Arising (attached) | CE | 5.40 |
| **4** | **REPORTS AND OTHER ITEMS FOR DISCUSSION/DECISION/APPROVAL** | | |
| 4.1 | Chairman's Report (oral) | CE | 5.45 |
| 4.1.1 | Election incident (attached) | CE | |
| 4.2 | Election of Deputy Chairman of Council of Governors (attached) | CE | 5.55 |
| 4.3 | Report back from sub-committee | | |
| 4.3.1 | Communications sub-committee report (draft minutes of 10 November 09 meeting attached) | CB | 6.00 |
| 4.3.2 | Membership report (attached) | AMC/SN | |
| 4.3.3 | Membership development and communication work plan (attached) | AMC/SN | |
| 4.4 | Term of office of Chairman* (attached) | CW | 6.15 |
| 4.5 | Terms of Reference Communications Sub-Committee* (attached) | CM | |
| 4.6 | Agreement of Meeting Dates and Time* (attached) | CE | |
| 4.7 | Council of Governors Funding Report* (attached) | Secretary | |

| | | |
|---|---|---|
| **5** | **ITEMS FOR INFORMATION** | |
| 5.1 | Membership of Sub-Committees and Trust Groups (attached) | CE |
| 5.2 | Agreement of Annual Cycle of Business (attached) | Secretary |
| 5.3 | Finance Report – October 2009 – to follow | LB |
| 5.4 | Performance Report – October 2009 (attached) | LB |
| 5.5 | Notes from Chief Executive's Strategy Workshop – to follow | HL |
| 5.6 | Foundation Trust Governors' Association Annual Report 2008/09 (attached) | Secretary |
| 5.7 | Who is who on the Council of Governors? (attached) | Secretary |
| 5.8 | Invitation to work with the Care Quality Commission (attached) | CM |
| **6** | **ANY OTHER BUSINESS** | |
| **7** | **DATE OF THE NEXT MEETING**<br>**11 February 2010 (time to be confirmed)** | |

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Council of Governors Meeting – 3 December 2009

| | |
|---|---|
| **AGENDA ITEM NO.** | 2.3/Dec/09 |
| **PAPER** | The Assessment of Quality - Patient Experience |
| **AUTHOR** | Andrew MacCallum, Director of Nursing |
| **EXECUTIVE LEAD** | Andrew MacCallum, Director of Nursing |
| **SUMMARY** | This paper outlines the approach The Trust takes to collect feedback from patients about the Trust's services and how the Trust seeks to understand patient experience better. |
| **ACTION** | For discussion and comment |

# The Assessment of Quality – Patient Experience

## 1.0 Introduction

1.1 How do we know what people think about our services? How do we find out about the experiences people have at Chelsea and Westminster?

1.2 *High Quality Care for All* published by the Department of Heath in 2008 identified three domains of quality care: safety, effectiveness and patient experience. The Trust emphasised its commitment to quality in its Annual Plan for 2008-2009 by aligning its aims and objectives with these three domains.

1.3 We want to improve the experiences people have at Chelsea and Westminster and one of our aims this year is to, *develop methods to understand and improve the patient experience***,** this means we need to actively find out what people think about our services and the experiences they have. We hope the Council of Governors will play an increasing role in this work as its membership development strategy takes root and grows.

1.4 The Trust has established three important working groups over the last year:

1.5 **THE PATIENT EXPERIENCE STEERING GROUP** which is a small senior group charged with overseeing the Trust's work in developing methods to understand and improve patient experience. This includes overseeing the Trusts strategy for surveying patients and developing new ways to capture patient feedback.

1.6 **THE PATIENT EXPERIENCE IMPROVEMENT GROUP** which is a larger group responsible for coordinating patient feedback across the Trust; particularly agreeing and tracking the action taken in response to feedback.

1.7 **THE COMPLAINTS, CLAIMS AND INCIDENT GROUP** is a small senior group that has been formed with the aim of ensuring any lessons to be learned from complaints, legal claims or untoward incidents are not missed and are used to improve the safety and experience patients have of the Trust's services.

## 2.0 How Do We Find Out What People Think About Our Service?

2.1 **Patient Surveys** – The Trust is required by the Care Quality Commission to participate in annual patient surveys. These surveys are conducted on a rolling annual programme and have included to date, inpatients, outpatients, children services, emergency departments and maternity services.

2.2 The results of these surveys are used in the Care Quality Commission's annual assessment of the Hospital.

### How are we doing?

2.3 In the 2008 inpatient survey 1,846 patients were sent questionnaires of which 685 (38%) responded. The questionnaire had 83 questions in 8 sections

1. Admission to Hospital
2. The Hospital and Ward
3. Doctors
4. Nurses
5. Your Care and Treatment
6. Operations and Procedures
7. Leaving Hospital
8. Overall (view of hospital admission)

2.4 Overall 94% of patients rated their care as good, very good or excellent. From the survey nine areas were identified where the Trust could do better:

- Information on how to complain
- Delays in discharge
- Asking patients to give their views on the quality of their care
- Keeping patients personal belongings safe
- Discussing with patients their concerns
- Giving the opportunity to families to talk to doctors
- Hospital food
- Improving information for families
- Ensuring patients who need to attend a hospital have the opportunity to choose to come to Chelsea and Westminster

2.5 In response to the above the Trust has for example:

- Reviewed the complaints process
- Introduced the Patient Experience Tracker (described below)
- Asked patients views of food and introduced a new menu
- Improved discharge procedures

2.6 **Patient Experience Trackers –** the Trust currently deploys Patient Experience Trackers (PET). The PET is a small electronic device which allows people to answer up to five questions. The answers are then collected electronically; which allows rapid and consistent reporting of results.

2.7 The Trust has an objective to survey 80% of all patients who are transferred or discharged from a ward. The questions asked on the PET have been informed by issues raised by patients in the annual patient survey. This is why the five questions currently on the PET for adult wards relate to communication (Fig 1).

Fig 1 **Current Patient Tracker Questions in Adult Wards**

| | |
|---|---|
| 1. | Were you kept well informed about your care and treatment by staff during your stay? |
| 2. | Did you feel involved in decisions made regarding your care and treatment? |
| 3. | Did staff answer your questions in a way that you could understand? |
| 4. | Were the staff friendly and approachable? |
| 5. | Overall how would you rate your experience on this ward? |

2.8 Patients can respond to each question by pressing a button for always, most of the time, sometimes, seldom or for question five, excellent, good, fair, poor.

2.9 The questions asked on our postnatal ward are different and based on the direct feedback from women (Fig 2).

Fig 2 **Current Patient Tracker Questions on the Postnatal Ward**

| | |
|---|---|
| 1. | Do you feel the ward is clean enough? |
| 2. | Did you feel welcomed when you arrived? |
| 3. | Did you get information you could understand? |
| 4. | Were the staff kind and caring? |
| 5. | Overall how would you rate your experience on this ward? |

2.10 This month the PET is being introduced to outpatient departments and clinics. The five questions for these areas are (Fig 3).

Fig 3 **Current Patient Tracker Question in Outpatients and Clinics**

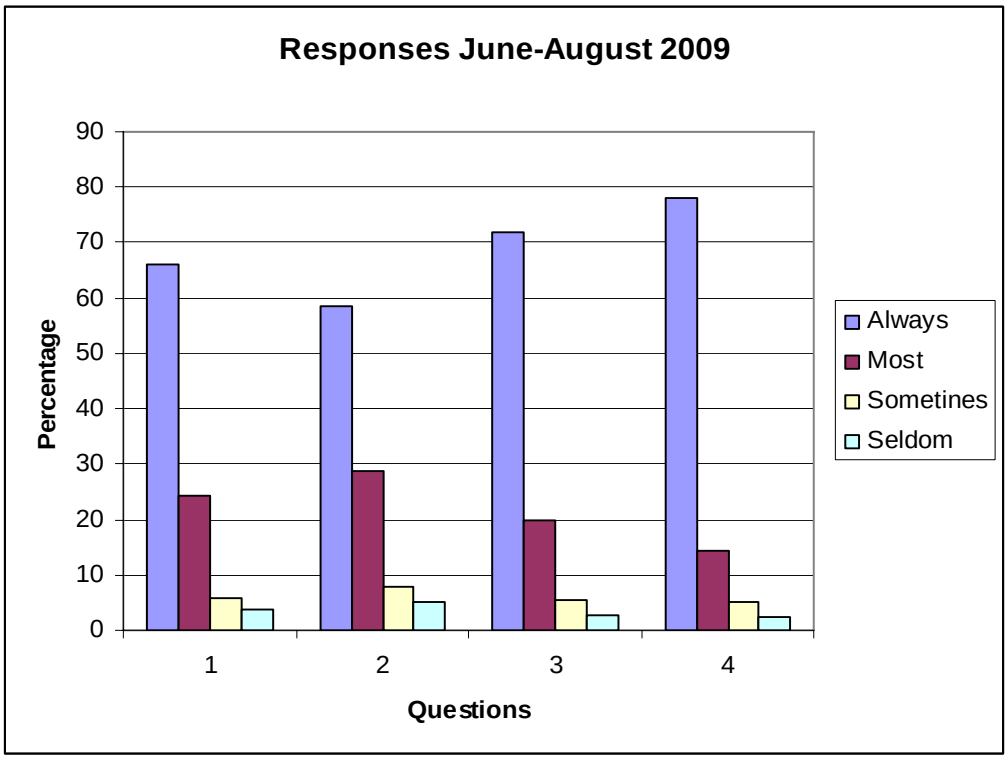
| | |
|---|---|
| 1. | How would you rate the process of booking of your appointment? |
| 2. | How would you rate the level of waiting time for your appointment? |
| 3. | Were staff friendly and approachable in outpatients today? |
| 4. | How would you rate the level of information supplied about any future appointments or treatment? |
| 5. | Were your questions answered in a way that you could understand? |

**How Are We Doing?**

**Adult and Postnatal Wards**

Responses to questions 1-4 for all wards surveyed between June-August 2009 are shown in Fig. 4 and 5.

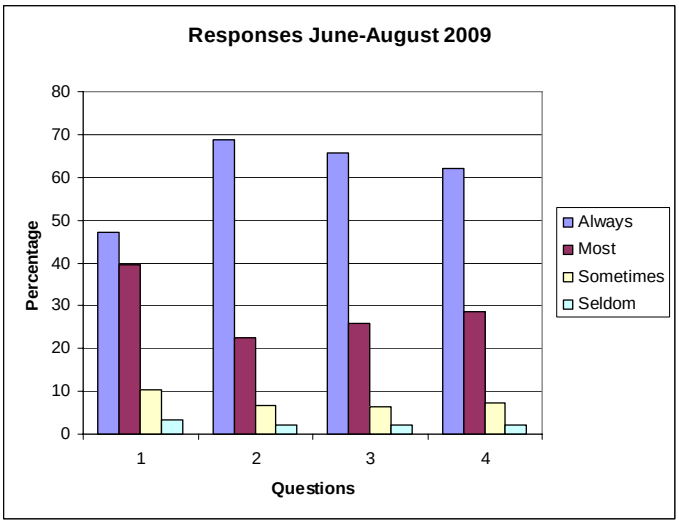
Fig 4 **Patient Tracker Questions (1to4) in Adult Wards**




**Questions**

| | |
|---|---|
| 1. | Were you kept well informed about your care and treatment by staff during your stay? |
| 2. | Did you feel involved in decisions made regarding your care and treatment? |
| 3. | Did staff answer your questions in a way that you could understand? |
| 4. | Were the staff friendly and approachable? |

Fig 5 **Patient Tracker Questions (1 to 4) in the Postnatal Ward**

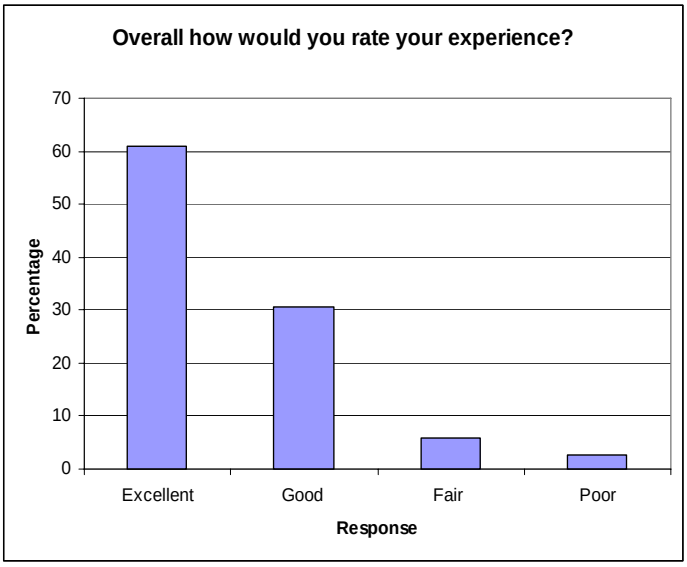



## Questions

| | |
|---|---|
| 1. | Do you feel the ward is clean enough? |
| 2. | Did you feel welcomed when you arrived? |
| 3. | Did you get information you could understand? |
| 4. | Were the staff kind and caring? |

The responses to question 5 for all wards between June-August 2009 are shown in Fig. 6.

Fig 6 **Patient Tracker Question (5) in Adult and Postnatal Wards**



## 3.0 Focused Surveys

3.1 As well as the national patients survey the Trust also surveys patients about specific services. Examples of the surveys undertaken recently are:

- Musculoskeletal Physiotherapy Service
- Ophthalmology Services
- Tuberculosis Services
- As part of the 'peer review' of the Trust's cancer services patients with lung, gynaecological, colorectal, urology and skin cancers have been surveyed

## 4.0 Comment Scheme

4.1 The Membership, Patients Advice and Liaison Service (M-PALS) have recently distributed new comment cards throughout the Trust. They are available on all wards and out-patient departments, as well as being available at the M-PALS office.

**How are we doing?**

4.2 M-PALS receive on average 25 comment cards per week.

4.3 M-PALS review every comment card received and give feedback to wards and departments. The *Trust News* features a monthly round-up of comments and feedback and there is a weekly item in the electronic Daily Notice Board. For example, during the past month, the Trust has received excellent feedback about the staff and services at 56 Dean Street; our efficient and friendly patient transport services and our Patient Hotel.

4.4 Feedback on what we could do better has included ensuring patients have booked appointments before attending the plastics hand dressing clinic; waiting time in Phlebotomy and the timeliness of our response when we ask patients to leave message on answer phones

## 5.0 How Do We Find Out About The Experiences People Have at Chelsea and Westminster?

**Patient Fora**

5.1 Talking to people is an important way to understand how the patient experience can be improved.

5.2 Recently a patients' forum has been formed by a mother whose child was treated in the hospital; she personally developed and ran the 'Parent to Parent' project within our paediatric department.

5.3 The mother gathered feedback from parents and carers of children being treated at Chelsea and Westminster who might otherwise be reluctant to provide feedback directly to hospital staff. She asked questions about admission and discharge procedures, doctors and nursing staff, the general paediatric service and the hospital environment.

5.4 The results from this project are currently being reviewed by the Trust and will be used to identify areas for improvement in our paediatric service.

5.5 Governors are invited to be involved in patients' fora and are asked to contact Sian Nelson, Membership and Engagement Manger for further information.

**Complaints**

5.6 Last year the Trust received 458 complaints. Each complaint told a story about the experience people have had at Chelsea and Westminster. Responding to people in a considerate and timely way is a priority but also learning lessons from complaints is important, particularly ensuring that any lessons learned and actions taken are followed through into real change for patients. The Hospital now records and tracks actions taken in response to complaints, to ensure that changes are made.

5.7 In April 2009 a new two-stage complaints process for health and social care was introduced; with the aim of transforming complaints handling, making it more comprehensive, accessible and patient-focused. The use of the terms 'informal' and 'formal' complaint has now been replaced with the terms 'concerns', 'comments' and 'complaints'. All complaints, comments and concerns are recorded and reported to the Board of Directors quarterly. This includes issues raised via M-PALS which were previously reported separately. This gives a more comprehensive view of patient feedback.

5.8 The Board of Directors report gives details of any changes made to services resulting from complaints and concerns along with an analysis of numbers of complaints received and any trends identified.

**How are we doing?**

5.9 Currently the top three areas of complaint or concern in the Trust are:

- **Information and Communication with Patients**
  This includes communications about cancellation or changes to appointments; information about waiting times or delays in clinics and decisions about care and treatment.

- **Appointment Issues**
  During the first two quarters of this year, 158 patients expressed concern about their appointments. Some of these concerns related to difficulty in accessing the appointments office.

- **Attitude or Behaviour of Staff**
  Patients raise concerns when staff are, abrupt, discourteous, uncaring or unhelpful.

5.10 In the last year as examples the Trust made the following improvements as a result of feedback from complaints:

- HIV/GUM Directorate has developed a discharge summary for all patients who are travelling and might need to access healthcare whilst abroad.

- Introduction of 'customer care training' in areas where poor staff attitude has been identified.

- Long-term Parents Forum has been established to support parents.

- The Admission Process for women requiring induction of labour has been reviewed. To ensure admissions are staggered and that all women receive the individual support they need.

- Introduction of the Productive Ward programme. A national initiative from the NHS Institute which focuses on improving ward processes to allow nurses to spend more time on direct patient care.

- 'Quiet cubicles' have been introduced in the Treatment Centre for patients suffering from anxiety.

- The Paediatric Admissions Office has amended their information literature to include contact numbers and travel cost reimbursement information.

- Paediatric Service has changed the waiting times relating to first appointments.

- Diabetic coding has been introduced to inpatient menus, making it clear which foods people with diabetes should choose.

- Improvement to the Trusts appointments office.

## 6.0 The Council of Governors

6.1 Governors will want to know about the experience people have of using our services, they may also have ideas about what areas they feel need to be improved or which seem to be working, well for patients.

6.2 The proposed Quality Sub-Committee of the Council of Governors will give Governors the opportunity to receive regular feedback on patients experience and contribute to identifying areas for improvement and areas where more work is required to better understand the experience people are having.

**Andrew MacCallum**
**Director of Nursing**
**November 2009**

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Council of Governors Meeting, 3 December 2009

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|---|---|
| **AGENDA ITEM NO.** | 2.4 /Dec/09 |
| **PAPER** | Quality Sub-Committee terms of reference |
| **AUTHOR** | Catherine Mooney, Director of Governance and Corporate Affairs |
| **LEAD** | Catherine Mooney, Director of Governance and Corporate Affairs |
| **EXECUTIVE SUMMARY** | Quality has been defined in 'Healthcare for All' as having three components, safety, effectiveness and patient experience. Quality Accounts will be required as part of legislation from April 2010. The exact format is not published yet as the consultation is ongoing but it is clear that stakeholder involvement will be an essential feature. In addition to this the Trust believes that the quality programme will be greatly enhanced by taking into account the views and expertise of our governors via a sub-committee. This sub-committee aims to utilise that expertise in developing and implementing a quality programme. It will also be the focus for the patient feedback initiatives described in the paper 'The assessment of quality (patient experience)'. |
| **DECISION/ ACTION** | The Council is asked to agree the terms of reference of the Quality sub-committee and to advise the Foundation Trust Secretary if willing to be a member of the committee. It is suggested that the meeting is chaired initially by one of the Executive Directors to provide the necessary insight into the quality legislation and relevant background from the Trust.<br><br>The Committee may decide to meet monthly initially. |

# Council of Governors Quality Sub-Committee

## Terms of Reference

### 1.0 Authority

1.1 The Council of Governors Quality Sub-Committee is constituted as a Sub-Committee of the Council of Governors to assist the Trust to develop and implement the Trust's quality programme.

1.2 Its terms of reference shall be as set out below and shall not be amended, revoked or replaced except by a resolution passed at a general meeting of the Council of Governors.

1.3 The Council of Governors shall not delegate any of its powers to the Sub-Committee and the Sub-Committee shall not exercise any of the powers of the Council of Governors.

### 2.0 Aim

This sub committee will provide key stakeholder input into the development and implementation of the Trust's quality programme, including safety, effectiveness and patient experience.

### 3.0 Role

3.1 To identify priorities for quality improvement in line with national and local initiatives.
3.2 To contribute to the structure and content of the Quality Account, within the required framework, to ensure it is clearly and well presented and can be understood by all stakeholders.
3.3 To advise on communication of the Quality Account, and quality initiatives including meeting the needs of a range of patients.
3.4 To identify ways in which stakeholders can be involved in the quality programme e.g. safety walkabouts, advising on leaflets.
3.5 To champion the patient's experience and encourage and advise on patient involvement.
3.6 To identify areas where there is particular added value from stakeholders.
3.7 To ensure that there is input from, and feedback to, all member constituencies.
3.8 To obtain the lay perspective on assurance of quality.

### 4.0 Membership of the Sub-Committee

4.1 The Sub-Committee shall comprise both elected and appointed governors with representatives from patients, the public, staff and PCTs.
4.2 Trust staff to include

a) The Director of Nursing
b) The Medical Director
c) The Director of Governance and Corporate Affairs

In attendance:

- Assistant Director of Nursing
- Membership and Engagement Manager
- Equality and Diversity Manager
- Head of Clinical Governance
- Other attendees by invitation

**5.0 Quorum**

5.1 A quorum shall comprise at least one of the Director of Governance and Corporate Affairs, Medical Director or Director of Nursing and three Governors.

**6.0 Frequency of Meetings**

6.1 The Sub-Committee shall meet bi-monthly and report to the Council of Governors after each meeting.

**7.0 Administration of the Meeting**

7.1 This will be undertaken by the Foundation Trust Secretary.

**8.0 Review**

8.1 The terms of reference of the committee shall be reviewed by the Council of Governors at least annually.

To be approved by the Council of Governors
December 2009

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Council of Governors Meeting, 3 December 2009

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| **AGENDA ITEM NO.** | 3.1 /Dec/09 |
| **PAPER** | Minutes of the meeting of the Council of Governors meeting held on 17 September 2009 |
| **AUTHOR** | Vida Djelic, Interim Foundation Trust Secretary |
| **LEAD** | Prof. Sir Christopher Edwards, Chairman |
| **EXECUTIVE SUMMARY** | This paper outlines a record of proceedings at the previous meeting. |
| **DECISION/ ACTION** | 1. To agree the minutes as a correct record.<br>2. The Chairman to sign the minutes. |

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

**Members' Council General Meeting**
Hospital Boardroom
**Chair:** Prof. Sir Christopher Edwards
**Date:** 17 September 2009
**Time:** 3:00 – 5:00 pm

**Present:**

| Constituency | Class | Name as desired | |
|---|---|---|---|
| Trust Board Chairman | | Prof. Sir Christopher Edwards | CE |
| Public | Kensington and Chelsea 2 | Sandra Smith-Gordon | SSG |
| Public | Hammersmith and Fulham 1 | Martin Bradford | MB |
| Public | Hammersmith and Fulham 2 | Christine Blewett | CBLE |
| Public | Wandsworth 1 | Mary Symons | MS |
| Public | Westminster 1 | Ann Mills-Duggan | AMD |
| Public | Westminster 2 | Martin John Lewis | ML |
| Patient | | June Bennett | JB |
| Patient | | Walter Balmford | WB |
| Patient | | Jane King | JK |
| Patient | | Jim Smith | JS |
| Patient | | Chris Birch | CBIR |
| Staff | Contracted | Alison Delamare | AD |
| Staff | Medical and Dental | Brian Gazzard (Deputy Chairman) | BG |
| Staff | Nursing and Midwifery | Sue P Smith | SPS |
| Staff | Support, Administrative and Clerical | Cathy James | CJ |
| Appointed | Wandsworth PCT | Dr David Finch | DF |
| Appointed | Royal Borough of Kensington and Chelsea | Cllr. Frances Taylor | FT |

| | | | |
|---|---|---|---|
| Appointed | Westminster City Council | Cllr. Cyril Nemeth | CN |
| Appointed | The Royal Marsden NHS Foundation Trust | Nicky Browne | NB |
| Appointed | Royal Brompton and Harefield NHS Trust | Duncan Macrae | DM |

**In attendance:**

| | | | |
|---|---|---|---|
| External Auditors | Deloitte LLP, Partner - Audit | Heather Bygrave | HB |
| Trust Board | Non-Executive & Vice Chairman | Charles Wilson | CW |
| Trust Board | Non-Executive | Andrew Havery | AH |
| Trust Board | Non-Executive | Karin Norman | KN |
| Trust Board | Non-Executive | Colin Glass | CG |
| Trust Board | Non-Executive | Richard Kitney | RK |
| Trust Board | Chief Executive | Heather Lawrence | HL |
| Trust Board | Director of Finance | Lorraine Bewes | LB |
| Trust Board | Medical Director | Mike Anderson | MA |
| Trust Board | Director of Nursing | Andrew MacCallum | AMC |
| Trust Board | Deputy Chief Executive | Amanda Pritchard | AP |
| Trust Executive | Director of Strategy | Amit Khutti | AK |
| Trust Executive | Dir. Of Governance | Catherine Mooney | CM |
| Secretariat | Interim FT Secretary | Dianne Holman | DH |
| Communications | Head of Communications | Matt Akid | MAK |
| MPALS | Membership & Engagement Manager | Sian Nelson | SN |

**1.1 Welcome & Apologies** **CE**

CE called the meeting to order and welcomed newly- appointed stakeholder representatives, Dr. Finch of NHS Wandsworth and Cllr. Nemeth of Westminster City Council.

CE noted the apologies tendered: Maria Elena Arana (patient)

**1.2 Declaration of Interests** **CE**

CE invited declarations of interest. None were tendered.

**1.3 Minutes of Previous Meeting held on 18 June 2009** **CE**

The minutes of the previous meeting held on 18th June 2009 were agreed as a correct record of proceedings. JB pointed out a typo on the cover sheet, '2008', for correction.

**1.4 Matters Arising** **CE**

CE noted that actions taken were in the paper. He referred to ref. 1.5 and reflected on the recent Chief Executive's Strategy Workshop which was one of the action points from the Joint Away Day. SSG commented that she found the workshop very useful.

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

CE said that having regard to the number of items on the agenda, there was nothing substantial to report.

**2.1 Report of the Task and Finish Group – Name of Members' Council and Members of the Council** **CE**

CE reported on the proceedings of the Members' Council task and Finish Group at which it was recommended that the names 'Governor' and 'Council of Governors' should be put to the Annual Members' Meeting for a vote after consulting the Board of Directors and then the Members' Council.

The Members' Council supported this recommendation.

MS asked if the name change to 'governors' would have any impact on the name of the Annual Members Meeting. CE confirmed that there would be no impact as all governors were members though not all members were governors.

**2.2 Report of the Task and Finish Group – governance arrangements (including Terms of reference agenda sub committee)** **CE**

CE invited the meeting to discuss item 2.3, Meeting times (oral), during this segment as it was related to the discussion of governance arrangements.

CBIR offered that there would be up to 15 new members after November's elections and it would be useful to attract and accommodate those members who are unable to leave work early. CBIR suggested a new starting time of 6:30pm. WB agreed in principle but suggested that a 6:00pm start was more appropriate.

CE invited the views of the members. There were a variety of views and a number of categories of individuals who could be affected by different starting times were identified.

**It was agreed that individual Council Members would be surveyed to determine the time for the next meeting only which is scheduled for** **VD**

**Thursday 3rd December 2009. The options proposed were: 4.30pm; and 6.00pm. The dates and times of the 2010 meetings will be agreed at December's meeting when the newly-elected Council Members are installed.**

CE continued with the report of the Task & Finish Group in response to the issues of:

- the excessive length of meetings;
- the need to focus on the most important issues;
- actively involving both lay and professional Council Members; and
- mechanisms to facilitate the optimal contribution of the Council and its members.

The meeting agreed to adopt the recommendations set out in the paper to address the concerns raised and approved the establishment of the Agenda Sub-Committee and the draft Terms of Reference presented to the meeting.

**The Quality Agenda will be discussed further at the next General Meeting of the Council when the newly-elected representatives are available to comment.** **CM**

**2.3 Meeting times (oral)** **CE**

This item was discussed under 2.2 above.

**2.4 Re-appointment of Non-Executive Directors** **CE**

KN and CW were excused from the meeting before the start of any discussion on account of conflict of interest.

**Charlie Wilson (CW)**

CE reported on the findings of CW's appraisal: CW continues to contribute effectively and demonstrate commitment to the role of Non-Executive Director, Vice Chairman and Senior Independent Director. CE invited the meeting to further consider that CW had been a tremendous supporter of the hospital for several years though his work was not always visible to the wider membership. His skills are very valuable to the Trust particularly at this time when the Trust is facing major change.

CE explained CW had served the Trust for a period of nine (9) years and in accordance with the NHS Foundation Trust Code of Governance was now subject to annual re-election. CE proposed the re-appointment of CW for a further term of one year.

There was unanimous support for CW's re-election.

**The meeting approved the re-appointment of CW for a further term of one year ending on 31st October 2010.** **CM**

CE also reported on recent information coming from the Foundation Trust Network in the previous week on the remuneration of Foundation Trust Non-Executives Directors. This indicated that most foundation trusts paid higher fees to their Vice-Chairs, Audit Committee Chairs and Senior

Independent Directors. CE noted that while C&W recognised the additional responsibilities of the role of Audit Committee Chair in setting remuneration, it had omitted to do the same for the roles of Vice Chair and Senior Independent Directors.

CE noted that CW held both these additional responsibilities and, in light of the new survey results coming to light, proposed that the annual remuneration for CW is increased to £18,000 (comparable to the Audit Committee Chair) for the new term in order to avoid perpetuating a situation that was inequitable. CE clarified that an increase was not being proposed for any other Non-Executive Directors.

Some members asked for more time to consider the proposal for increased remuneration as this was not included in the paper as they would have expected. CE explained that he felt that it was more appropriate to afford the candidate some discretion and privacy. Some members disagreed and felt that it was fair to put this in the public domain.

It was suggested that this issue was referred to a sub-committee. DH advised the meeting that the Constitution stated that it was the role of the Members' Council to decide remuneration. The nominations Committee was responsible for appointments of Non-Executive Directors rather than remuneration. Another member commented that it would not be fair on the candidate to defer the decision to a later general meeting.

It was agreed that in future any proposed changes to the terms and conditions on re-appointment would be circulated in advance of the general meeting.

**The meeting agreed to increase the annual remuneration of CW to £18,000 with effect from 1st November 2009.** **CM**

**Karin Norman (KN)**

CE reported on the findings of KN's appraisal: KN continues to contribute effectively and demonstrate commitment to the role of Non-Executive Director. In particular, CE praised KN's advice and work in the development of treasury policy which enabled the Trust to be pro-active and avoid the catastrophic consequences of the collapse of the banking sector in 2008. CE proposed the re-appointment of KN for a further term of three years.

There was unanimous support for KN's re-election.

**The meeting approved the re-appointment of KN for a further term of three years ending on 31st October 2012.** **CM**

CW and KN were then invited to rejoin the meeting and were informed of the decisions and congratulated.

**2.5 Policy for the Composition of the Non-Executive Directors[1]** **CE**

CE invited the meeting to consider the draft policy which was a

[1] Constitution 12.5.1

requirement of the Constitution.

In relation to the eligibility requirements of Non-Executive Directors set out in the Constitution, MA advised that Imperial College was no longer part of the University of London. The meeting noted the change in circumstances and approved the policy.

**2.6 Report on Chair Appraisal** **CW**

For this part of the meeting, CE vacated the Chair and was excused from the meeting. The Vice Chairman of the Board of Directors, CW, presided over the meeting in his absence in accordance with the provisions of the Constitution.

CW thanked, on behalf of BG, those Council Members who took part in the appraisal of the Chairman and presented the report to the meeting. One member said that there was enormous support for the Chairman but asked if the criticisms made by Council Members were conveyed to the Chairman. CW confirmed that this was done and the issues and recommendations for the improvement of the effectiveness of meetings had been incorporated in CE's paper which was discussed at the Task & Finish Group.

The meeting noted the report. CE was then invited to re-join the meeting. CW then handed the Chair back to CE for the remainder of the meeting.

**2.7 Membership Development and Communication work plan** **AMC**

AMC introduced the annual work plan and invited SN to talk the group through the highlights.

SN described the key activities which would enable the Members' Council Communications Sub-Committee to meet the objectives of its Membership Development and Implementation Strategy. SN pointed to the numerous patient forums set up within the hospital that represent specific clinical areas of care and invited Council Members to get involved.

In response to CBIR, SN confirmed that approximately 200 members were recruited in the campaign leading up to the Annual Members' Meeting.

JB noted that 'public' was omitted from the list of members in paragraph 3.0 of the annual plan. AMD said that plan should make clear the reasons why the membership should support this particular foundation trust.

MS felt that there was a problem with the branding of the Trust and asked if it was a local or a national hospital. HL referred to the recently held Strategy Workshop which addressed the future of the hospital – both its local and specialist facets and noted that the Trust is increasingly being recognised for a number of specialist services. CE felt strongly that the NHS was first and foremost a national service and a patient should be able to go the expert in their condition. FT's view was that the hospital was popular because it was perceived as a local hospital.

**The meeting asked for the work plan to be updated with the amendments requested by JB and AMD and consistent application of** **SN**

**the terminology for the Members' Council and then brought back to the Members' Council.**

**2.8 Complaints Policy** **AMC**

AMC presented a paper on the changes to the Complaints Policy, both local resolution and second stage and how these would be implemented.

CN asked if the Trust was responsible for meeting the cost of liability arising from complaints out of its own funds. CE explained that the NHS Litigation Authority settled the liability from a pool of funds to which individual Trusts contribute in accordance with their individual risk ratings.

CBIR suggested that the time targets for resolution set out on pages 3 and 4 were not realistic given current performance levels. DF asked if there was a reporting mechanism to monitor the achievement of targets. HL explained that a reporting mechanism was in place and in 90% of cases, the time targets were met.

**2.9 Presentation of Annual Report & Accounts 2008/09[2]** **LB**

LB stated that it was a statutory responsibility to present the Annual Report and Accounts to the Members' Council. LB described the main contents of the Annual Report 2008/09 and explained that it had been laid before Parliament.

LB highlighted the financial performance of the Trust in 2008-09 which included:

- A surplus of £9.6million
- A financial risk rating from Monitor of 5 out of 5, where 5 is low risk and the top rating that an FT can achieve
- Capital expenditure of £19 million (double the level in the preceding period)
- Remaining within the authorised prudential borrowing limit
- 'Green' rating from Monitor for Governance
- 'Green' rating from Monitor for Mandatory Goods and Services

LB then invited questions.

CBIR asked if 18 Dean Street was funded by PCTs. LB and HL explained that they contributed indirectly as they paid the Trust for the care of patients. It was also noted that as a Foundation Trust, there was no longer the requirement to get the NHS to contribute funding for capital projects.

The meeting adopted the report.

WB congratulated LB on the marvellous job done in producing the Annual Report. LB explained that it was a team effort.

**2.10 External Auditors' Report** **HB**

HB introduced the audit letter and explained its purpose and the responsibilities of her firm. HB confirmed that she was able to issue an

[2] Constitution 17.6

unqualified (or 'clean') opinion on the Trust's accounts for the year ended 31 March 2009 within the deadline set by Monitor. HB also confirmed that there were no significant audit adjustments and that the Trust's management had formulated an action plan for the implementation of her firm's recommendations for improving internal controls. HB also confirmed the independence of her firm within the meaning of all regulatory and professional requirements.

There were no questions from Council Members. The meeting noted the report.

**2.11 Report of the Audit Committee[3]** **AH**

AH introduced the Audit Committee as a sub-committee of the Board of Directors and described its responsibility in providing assurance to the Board and in reporting to the Members' Council. AH explained that the Audit Committee found that the Trust's risk management, control and governance processes were adequate and effective and could be relied upon by the Board; and weakness in internal control identified would be dealt with by senior managers under the action plan.

**SSG commented that many Council Members were not financially literate and asked if there could be a workshop similar to those held in late 2008 to enhance their skills.** **LB**

WB commented that it was very sensible to base the depreciation charge on a residual value of 50% rather than nil at the end of the life of the building.

The meeting noted the report.

**2.12 Re-Appointment of the Auditor[4]** **AH**

HB was excused from the meeting before the start of this discussion.

CE introduced the discussion by citing the long association of the auditors with the engagement and explained that the trust had thought through the issue quite carefully having regard to independence requirements.

AH explained that the partner rotation scheme operated by the firm is a mitigating factor but that it was proper that the audit should be market tested in 2011.

One member asked about the quantum of fees paid to the audit. LB explained that this was disclosed in the Annual Report earlier presented to the Members' Council and depended on the size of the NHS organisation as set out in very clear guidance.

The meeting approved the re-appointment of Deloitte as auditor for a term of one year ending 30th September 2010.

[3] Code F.3.2

[4] Code F.3.5 / Constitution 16.4

**2.13 Single Equality Scheme** **AP**

AP informed the meeting that the Trust was developing a Single Equality Scheme to replace the earlier scheme. This goes to the Board of Directors in October 2009. AP asked Council Members with an interest in Equality and Diversity to feed back to Priti Bhatt on the Work Plan. Leaflets were available on the way out of the meeting.

**2.14 Funding Report and request for allocation for website development** **MA**

CBIR asked if the directory of the Trust's services for adults had been accounted for in arriving at the 2009-10 unallocated budget of £47,261. CM said that it had been omitted. *Post meeting note: On page 1 where the table reads 'Children's Services £19,817' this should have read 'Adult Services £19,817'. Only one directory is funded by the Members' Council and that is the Adult Service Directory. Therefore, the figure for the unallocated budget 09-10 of £47,261 is correct.*

In relation to the funding of the website, some members thought that it was inappropriate to ask the Members' Council to allocate funding for what was an operational priority for hospital funding. HL explained that the funds which the Members' Council had been invited to allocate belonged to the hospital and was not a separate pot. BG agreed with the principle that the Members' Council should have some discretion to allocate the funds as they thought best but urged Council Members to approve the funding for the website as it was a high priority item. CE commented that the website gave members the ability to interact with the hospital and is in keeping with the aims and objectives of the Members' Council.

CBIR commented that there was no budget (outside of printing) for the Trust News. MAK said that that the budget was intended for particular projects and the Team should be able to be creative in raising funds.

AMD asked if the website developments would enable both information outwards and information upwards. MAK confirmed that it would enable both.

The meeting approved the request for funding of the website development.

**3.1 Finance Report – July 2009** **LB**

This paper was noted.

**3.2 Performance Report – July 2009** **LB**

This paper was noted.

**3.3 Membership Report** **SN**

This paper was noted.

**4 ANY OTHER BUSINESS**

There being no further business the meeting adjourned.

## 5 DATE OF THE NEXT MEETING 3rd December 2009

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Council of Governors Meeting, 3 December 2009

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| **AGENDA ITEM NO.** | 3.2/Dec/09 |
| **PAPER** | Matters Arising from the meeting of the Council of Governors meetings held on 17 September 2009 |
| **AUTHOR** | Vida Djelic, Interim Foundation Trust Secretary |
| **LEAD** | Prof. Sir Christopher Edwards, Chairman |
| **EXECUTIVE SUMMARY** | This paper lists matters arising from previous meeting(s) 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**
**Members' Council General Meeting**

Hospital Boardroom
**Chair:** Prof. Sir Christopher Edwards
**Date: 17 September 2009**
**Time: 4:30 – 6:30 pm**

| Ref | Description | Lead | Subsequent Actions or Outcomes |
|---|---|---|---|
| 2.2 | **Report of the Task and Finish Group – governance arrangements** | | |
| | **It was agreed that individual Council Members would be surveyed to determine the time for the next meeting only which is scheduled for Thursday 3rd December 2009.**<br>**The options proposed were: 4.30pm and 6.00pm**<br>**The dates and times of the 2010 meetings will be agreed at December's meeting when the newly-elected Council Members are installed.** | **VD** | **New governors to be surveyed** |
| | **The Quality Agenda will be discussed further at the next General Meeting of the Council when the newly-elected representatives are available to comment.** | **CM** | **Paper on agenda** |
| 2.7 | **Membership Development and Communication work plan** | **AMC** | |
| | **The meeting asked for the work plan to be updated with the amendments requested by JB and AMD and consistent application of the terminology for the Members' Council and then brought back to the Members' Council.** | **SN** | **Paper on agenda** |

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| **2.11** | **Report of the Audit Committee** | **AH** | |
| | **SSG commented that many Council Members were not financially literate and asked if there could be a workshop similar to those held in late 2008 to enhance their skills.** | **LB** | **To be arranged** |

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Council of Governors Meeting, 3 December 2009

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|---|---|
| **AGENDA ITEM NO.** | 4.1.1 /Dec/09 |
| **PAPER** | Election Incident |
| **AUTHOR** | Catherine Mooney, Director of Governance and Corporate Affairs |
| **LEAD** | Prof. Sir Christopher Edwards |
| **EXECUTIVE SUMMARY** | This paper describes an incident relating to election of a Governor in November 2007. |
| **DECISION/ ACTION** | The Council is asked to agree on the way forward to replace the vacant seat.<br>The options are<br>1. Ask the second highest polled candidate to join the Council of Governors<br>2. Undertake an election next year |

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

**Election Incident Briefing for Council of Governors December 09**

**1. Background**

The public constituencies of the Trust are divided into two for each borough i.e. Hammersmith and Fulham Area 1 and 2, Wandsworth Area 1 and 2 and Kensington and Chelsea Area 1 and 2.

This incident occurred during the election in November 2007. The election was conducted by Electoral Reform Services (ERS) and covered elections to the public and patient constituencies.

**2. Identification of Incident**

Martin Bradford (MB), a member of the Council of Governors representing Hammersmith and Fulham Area 1 contacted the Director of Governance and Corporate Affairs to highlight that he thought he lived in the ward of Palace Riverside which is in Hammersmith and Fulham Area 2.

This was confirmed by checking the current membership database which had his correct address and post code and which was indeed in the Hammersmith and Fulham Area 2. It appeared that MB had been elected to Hammersmith and Fulham Area 1 seat in November 07 for which he was not eligible as he did not live in that area.

In addition, MB has said that he understood that he applied to be a patient and when he did not appear on the patient ballot papers, had informed ERS. ERS re-ran the ballot for the patient constituency but he was not on the list again. MB contacted ERS again and they said they would look into it but the next communication from ERS was to inform him that he had been elected to the Hammersmith and Fulham Area 1 seat. The Trust was notified accordingly. MB duly attended the next Members' Council meeting in Feb 08 and was welcomed as the Hammersmith and Fulham Area 1 representative.

**Incident Investigation**

Investigations show that MB completed a nomination form and ticked the section for Hammersmith and Fulham Area 1 (rather than the patient constituency box) and signed it. The form does stipulate that it is his responsibility to confirm eligibility.

ERS were appointed as the Returning Officer. One of the roles of the Returning Officer is to check eligibility (section 14 of the Chelsea and Westminster Hospital NHS Foundation Trust Council of Governors Election Rules). Apparently ERS were sent the membership database and so were in a position to do this. However, instead the list of nominations was sent to the Foundation Trust Secretary to confirm that the nominees were eligible. The Foundation Trust Secretary confirmed that they were correct. In fact, this was not the case as MB was listed as Hammersmith and Fulham Area 1 when a check of the database would have shown he lived in Area 2. . It therefore appears that a mistake was made by MB which was not picked up in the checking process.

**Immediate actions taken**

Clarification was sought from the company undertaking the current election, Opt2Vote as to their responsibilities and they were clear that it is their role to check eligibility. In addition a further check was undertaken by the Membership and Engagement Manager on all candidates and the current Governors eligibility. This confirmed that all are eligible.

Monitor was informed by telephone on 20 Oct 09 and the incident has been included in the governance commentary section of the Q2 submission to Monitor.

**Implications**

MB attended eight meetings over the two years. There are no minuted records attached to his name and there were no decisions made that were not unanimous or which required a vote during those meetings.

**Next steps**

MB cannot hold his post any longer and based on legal advice taken the options are as follows:

1. Invite the second highest polling candidate to join the Council of Governors
2. Undertake a further election next year

The results of the election in November 2007 were that MB polled 22 votes and the next candidate polled 17 votes, which were 22 and 31 respectively by the final stage of the transferable vote system. As the election was two years ago, a new election is probably the best option. We have received no nominations for the Borough of Wandsworth Area 2 and Kensington and Chelsea Area 1 in the current election so can agree a timetable to include these seats also.

**Recommendations**

Election briefing notes are being prepared which will include confirmation that the Returning Officer will work to the election rules as outlined in the Chelsea and Westminster constitution, which includes checking the validity of nominees. A further check will be undertaken by the Trust. The nomination form will be re-designed to clarify the constituencies and how further information can be obtained. The election publicity for public governors will include clarity on the borough boundaries.

**Report from ERS**

We have received no report from ERS as yet.

Catherine Mooney
Director of Governance and Corporate Affairs
November 2009.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Council of Governors Meeting, 3 December 2009

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|---|---|
| **AGENDA ITEM NO.** | 4.2/Dec/09 |
| **PAPER** | Election of Deputy Chairman of Council of Governors |
| **AUTHOR** | Vida Djelic, Interim FT Secretary |
| **LEAD** | Prof. Sir Christopher Edwards, Chairman |
| **EXECUTIVE SUMMARY** | In accordance with the Trust's constitution the Council of Governors is required to appoint a Deputy Chair. Nominations should be forwarded in writing to the Chair (or via email to vida.djelic@chelwest.nhs.uk) by 31 December 2009.<br>Individuals can nominate themselves. The current Deputy Chair, Brian Gazzard, has been Deputy Chair for the last three years. The constitution does not define a term of office but is reasonable to assume a three year term, as for non-executive directors. The term of the current Deputy Chair can be extended.<br><br>The role of the deputy chair required clarification as the constitution contains some contradictions. This is contained in this revised paper.<br><br>In addition, Monitor have introduced 'lead governors' and this is further explained. The lead governor can also be the deputy chair of the Council of Governors. |
| **DECISION/ ACTION** | The Council of Governors is asked to nominate and appoint a Deputy Chair for the Council of Governors following the process outlined. The results or election will be undertaken prior to the next meeting. |

# APPOINTMENT OF A DEPUTY CHAIRMAN OF THE COUNCIL OF GOVERNORS

## 1.0 INTRODUCTION

The Council of Governors is required to appoint a Deputy Chair of the Council of Governors as per the Trust's Constitution section 11.11

'The Council of Governors shall appoint one of the Governors to be Deputy Chairman of the Council of Governors'.

## 2.0 ROLE OF THE DEPUTY CHAIR

The role of the Deputy Chair is described in the constitution as follows:

### 2.1 Constitution

'10.11. The Chairman of the Foundation Trust, or in their absence the Deputy Chairman of the Council of Governors, shall act as chairman at all members meetings of the Foundation Trust. If neither the Chairman nor the Deputy Chairman of the Council of Governors is present, the members of the Council of Governors present shall elect one of their number to be Chairman and if there is only one Governor present and willing to act they shall be Chairman.'

This indicates that the Deputy Chair of the Council of Governors may deputise for the Chairman at members meetings. Members meetings are meetings of the members, which are required to be held within nine months of each financial year .i.e. the annual members meeting. All members meetings other than annual meetings are called special members meetings.

However, the Deputy Chair of the Council of Members may not deputise for the Chairman at Council of Governors meetings as per section 11.17.5

'11.17.5. The Chairman of the Foundation Trust or, in their absence, the Vice Chairman of the Board of Directors, or in their absence one of the non-executive Directors is to preside at meetings of the Council of Governors. If the person presiding at any such meeting has a conflict of interest in relation to the business being discussed, the Deputy Chairman of the Council of Governors will chair that part of the meeting.

## 3.0 LEAD GOVERNOR

Monitor has written to Trust Chairs to request the nomination of a lead governor.

The role is described as follows:

Extract from Monitor: Your Statutory Duties - A reference guide for NHS foundation trust governors.

‘The chair of the board of directors is also the chair of the board of governors. The NHS foundation trust may decide that one governor should lead the board for governors where it is not considered appropriate for the chair or another one of the non-executive directors to do so. These occasions are likely to be infrequent but on example may be a meeting discussing the appointment of the chair.

The lead governor could also have a role in certain circumstances where it would not be appropriate for the chair to contact Monitor, or Monitor to contact the chair (for example, in relation to appointment of the chair). Communication would instead take place between the lead governor and Monitor in such circumstances. Routine communication from Monitor to governors will, as a mater of course, be disseminated via board secretaries.

The existence of lead governor does not, in itself, prevent any governor from making contact with Monitor directly if they feel it is necessary.

It is suggested that the term lead governor is used to, prevent confusion with the deputy chair. Alternative titles such as vice chair or presiding governor have also been suggested.

The lead governor should be chosen by the board of governors. The lead governor should not deputise for the deputy chair of the board of directors.’

**3.1 Proposal for lead governor**

It is proposed that the Deputy Chair of the Council of Governors is also the lead governor as defined by Monitor. Please note, in the above, the reference to Deputy Chair is intended to be the Deputy Chair of the Board (called Vice-Chair at Chelsea and Westminster) as the Monitor model constitution does not contain any references to a deputy chair of the Council of Governors.

**4.0 PROCESS FOR SELECTION**

4.1 It is proposed that any patient, public, staff or appointed representative member may stand for the position of Deputy Chair.

4.2 Members’ can nominate themselves – they are not required to be seconded.

4.3 All nominations should be addressed in writing to the Chair at the following address:

Prof. Sir Christopher Edwards
Chair
Chelsea and Westminster NHS Foundation Trust
369 Fulham Road
London SW10 9NH

Or via email to vida.djelic@chelwest.nhs.uk. All nominations should be received no later than 5pm on 31 December 2009.

4.4 If more than one member expresses interest in the role, a secret ballot will take place prior to the next meeting in February 2010.

The Council of Governors is asked to nominate and appoint a Deputy Chair for the Council of Governors following the process outlined.

Vida Djelic
Interim FT Secretary

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Council of Governors Meeting, 3 December 2009

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|---|---|
| **AGENDA ITEM NO.** | 4.2/Dec/09 |
| **PAPER** | Election of Deputy Chairman of Council of Governors |
| **AUTHOR** | Vida Djelic, Interim FT Secretary |
| **LEAD** | Prof. Sir Christopher Edwards, Chairman |
| **EXECUTIVE SUMMARY** | In accordance with the Trust's constitution the Council of Governors is required to appoint a Deputy Chair. Nominations should be forwarded in writing to the Chair (or via email to vida.djelic@chelwest.nhs.uk) by 31 December 2009.<br>Individuals can nominate themselves. The current Deputy Chair, Brian Gazzard, has been Deputy Chair for the last three years. The constitution does not define a term of office but is reasonable to assume a three year term, as for non-executive directors. The term of the current Deputy Chair can be extended. |
| **DECISION/ ACTION** | The Council of Governors is asked to nominate and appoint a Deputy Chair for the Council of Governors following the process outlined. |

# APPOINTMENT OF A DEPUTY CHAIR OF THE COUNCIL OF GOVERNORS

## 1.0 INTRODUCTION

The Council of Governors is required to appoint a Deputy Chair of the Council of Governors as per the Trust's Constitution.

## 2.0 PROCESS FOR SELECTION

2.1 It is proposed that any patient, public, staff or appointed representative member may stand for the position of Deputy Chair.

2.2 Members' can nominate themselves – they are not required to be seconded.

2.3 All nominations should be addressed in writing to the Chair at the following address:

Prof. Sir Christopher Edwards
Chair
Chelsea and Westminster NHS Foundation Trust
369 Fulham Road
London SW10 9NH

Or via email to vida.djelic@chelwest.nhs.uk. All nominations should be received no later than 5pm on 31 December 2009.

2.4 If more than one expresses interest in the role, a secret ballot will take place prior to the next meeting in February 2010.

## 3.0 ROLE OF THE DEPUTY CHAIR

3.1 This requires clarification in light of the constitution and the role of lead Governor, and further information will be provided at the Council of Governors meeting.

## 4.0 DECISION/ACTION REQUIRED

The Council of Governors is asked to nominate and appoint a Deputy Chair for the Council of Governors following the process outlined.

Vida Djelic
Interim FT Secretary

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Council of Governors Meeting, 3 December 2009

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|---|---|
| **AGENDA ITEM NO.** | 4.3.1/Dec/09 |
| **PAPER** | Draft minutes of the meeting of the Council of Governance Communications Sub-Committee held on 10 November 2009 |
| **AUTHOR** | Vida Djelic, Interim FT Secretary |
| **LEAD** | Chris Birch, Acting Chairman |
| **SUMMARY** | This is a draft of proceedings at the meeting held on 10 November 2009 |
| **DECISION/ ACTION** | The meeting is asked to agree the minutes. |

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

**Council of Governors Communications Sub-Committee, 10 November 2009**

**Draft Minutes**

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|---|---|---|---|
| **Attendees** | Chris Birch | CB | Acting Chairman |
| | June Bennett | JB | Patient Governor |
| | Jim Smith | JS | Patient Governor |
| | Sandra Smith Gordon | SSG | Public Governor – Kensington & Chelsea |
| **In attendance** | Jane Tippett | JT | Assistant Director of Nursing |
| | Renae McBride | RM | Editor of Trust News/Communications Manager |
| | Sian Nelson | SN | Membership and Engagement Manager |
| | Matt Akid | MA | Head of Communications |
| | Andrew MacCallum | AMC | Director of Nursing |
| | Catherine Mooney | CM | Director of Governance and Corporate Affairs |
| | Vida Djelic | VD | Interim FT Secretary |

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|---|---|---|
| **1** | **Welcome and Apologies** | **CB** |
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| | CB opened the meeting by welcoming Vida Djelic as a new Interim FT Secretary to her first meeting of the Communications Sub-Committee. | |
| | | |
| | Apologies were received from George Vasilopoulos and Priti Bhatt. | |
| | | |
| | There are vacant seats at present due to MR and AD leaving the membership. We will seek volunteers from the Council of Governors to fill in the gaps. CB suggested that he as Acting Chair of the sub-committee should write a letter to Martin Rowell and Alison Delamare thanking them for attending the communications sub-group meetings and for their valuable contributions. | **CB** |
| | | |
| **2** | **Minutes of previous meeting 3 September 2009** | **CB** |
| | | |
| | Minutes of the previous meeting were accepted as a true and accurate record with the following changes: | |
| | p.4 section 9 - budget allocation: it should state that the sub-committee agreed to recommend to the Council that it should pay £12,800 for the development of the Trust website. | **VD** |
| | | |

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| **3** | **Matters Arising** | **CB** |
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| | JB was not aware that the consultation on the Equality and Diversity Single Equality Scheme had started. | |
| | SN said it has been completed before it was brought to the attention of the Council of Governors Communications Sub-Committee. | |
| | | |
| | CM pointed out that the matters arising document needs to be renumbered to make it clear which items from the minutes it refers to, and this should be in place for future meetings. | |
| | | |
| **4** | **Communication methods with Members** | **SN** |
| | | |
| | SN outlined the main points of the paper circulated to the sub-committee prior to the meeting. Historically, communications with members has been restricted to two mail shots per year.<br><br>SN stressed the importance of keeping in touch with members regularly throughout the year and to ensure that members have access to participation in Trust matters which are outlined in the membership application agreement. The aim is to create communication methods that allow the Council of Governors to be in regular contact with members of the Trust, ensuring accessibility to Trust activities, and for the Trust to benefit from patient and public involvement in a way that there are no disruptions caused by the postal strike or similar external problems.<br><br>SN said that the mailing would cost £2,664 to request all patient and public members to update their contact details. SN pointed out that those members who do not have a computer at home could access computer at the hospital. Capita, a company managing the membership database, would do mailing on behalf of the Trust.<br><br>MA asked if SN has knowledge if such an exercise has been successful with other members of Capita. SN said she would follow this up.<br><br>SN mentioned that we would also consider those people needing Learning Disability support services by including a question ‘do you consider yourself to have a learning disability’.<br><br>JB suggested that the Trust News is a very effective way of keeping members updated.<br><br>SSG asked if there was a membership area on the C&W website designated to members only. She felt that it would be good to have such an area on the website to use for disseminating information. SN said that the Trust is working towards it.<br><br>AMC said it would be better to have a function on the website which would allow people to change from surface mail to e-mail. | **SN** |

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| | The sub-committee agreed that it would be useful for the Trust to have e-mail addresses of its members in order to communicate with them in a more economic and effective way. AMC stressed that it was important not to have a two tier system. It was suggested that this could be included with the next election mailing or the April newsletter mailing. | |
| | | |
| 4.1 | Membership application forms paper drafted by SN was tabled at the meeting. SN will circulate the paper and invite any comments from the sub-committee. | **SN** |
| | | |
| 4.2 | SN tabled a welcome pack letter at the meeting. SN will circulate the draft letter and invite any comments from the sub-committee. | **SN** |
| | | |
| **5** | **Members recruitment script** | **SN** |
| | | |
| | Jane Tippett joined the meeting. | |
| | | |
| | SN explained that the Campaign Company created a standard recruitment script for the use of staff, volunteers, the Council of Governors and other membership support personnel. In order to engage potential members, all staff should be able to recruit new members. SN emphasised that it is a basic script for the Trust staff, which is optional. | |
| | | |
| | SSG felt that the medical staff are already very busy and that this may not be appropriate in a clinic setting. | |
| | | |
| | AMC stressed that it is the appropriateness that is the key to it. He suggested that when a new patient registers then the Trust could recruit a new member. He felt that the outpatients are more likely to be willing to register. | |
| | | |
| | CB emphasised that it is very important to be tactful and to make it clear how we use it. | |
| | | |
| | JB asked for clarification of use of affiliated members as she was not aware of their existence. | |
| | | |
| | SN said that there are 500 affiliate members and that those are the members who are neither patients nor leaving in local boroughs, they do not vote but have an interest in supporting the Hospital in many different ways. It was agreed that SN would clarify this. | **SN** |
| | | |
| | CM suggested that SN amends the paper on the membership recruitment by focusing on what the Trust has achieved rather than introducing it from the beginning as we have passed the beginning stage. | |
| | | |
| | JT pointed out that a lot has been done with the patient experience tracker. | |
| | | |
| **6** | **Governors induction** | **CM** |

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| | CM explained the purpose of the induction meeting she was going to set up was to get some views and ideas on what should form the part of the induction for new Governors who are due to join in the Council at the end of November.<br><br>CM outlined some major points to be covered in the induction and these were as follows:<br>• The value of the Council of Governors<br>• The role of the Council of Governors<br>• Key facts and documents<br>• Trust finances overview<br>• Trust services | |
| | | |
| | CB expressed his opinion that not too much information should be delivered to new governors in a small space of time. His interests would be more around learning about the hospital itself, the Trust Board and the Trust Executive. | |
| | | |
| | JB agreed with CB and suggested that some information could be delivered in writing. | |
| | | |
| | MA suggested that new members might be interested in being taken on the tour around the hospital. CM said that there would not be enough time to cover both the induction and the tour at the same time. | |
| | | |
| | JS agreed that it is very good idea and that it was impossible to have the tour during the induction to arrange it at a later stage. | |
| | | |
| | AMC was concerned about people with learning difficulties who may be attending the induction and how they would feel having to spend 3 hours in a small room. He suggested that those people should be accommodated. | |
| | | |
| | CM said it was a bit late to change this but that it should be considered as a part of a wider induction process. | |
| | | |
| | JT reported that she was going to meet a friend, who had some knowledge of Southampton Members Council where members moved around the room so there was an opportunity to speak with the Board members and the staff. JT felt it very important that members understand aims and objectives of the hospital. | |
| | | |
| | JB said that it would be very useful that new members know which wards the C & W Hospital has. | |
| | | |
| | JB suggested more information on focus groups and sub-committees. | |
| | | |
| **7** | **Children and Young persons' membership** | **SN** |
| | | |

| | | |
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| | SN expressed her view that it might be a good idea to encourage young people to join the Trust and gave some suggestions. She outlined the proposal to create a Children's and Young Persons' membership. | |
| | | |
| | SN informed the sub-committee that she had already made enquiries with a selection of Trusts and that some of Trusts had very impressive results. One of these was Sheffield Trust. They have 14+ young associates. Sheffield Trust has on its website an area for kids and they have an entertainment area which from her point of view helps the trust expand and engage more with young people. | |
| | | |
| | SN had a view that acknowledging the children and young persons' membership on the constitution would ensure that this membership group have a greater position to truly represent themselves e.g. having a young persons' champion on the Council of Governors. | |
| | | |
| | JS suggested that we should use more electronic communications when communicating with young people as he thought they are very sophisticated. | |
| | | |
| | SSG had a concern about funding of this new group. | |
| | | |
| | SN explained that it is still an early stage to discuss the funding and that there are some other issues which need to be considered and agreed with the Council of Governors. We would first need to establish such a group and then get the funding arrangements in place. | |
| | | |
| | CM made the sub-committee aware that if the Trust was to establish a new category of membership it would then need to adjust its constitution and this should be presented at the Annual Members' Meeting in 2010. | |
| | | |
| | AMC pointed out that if would be a good idea to have children on work experience. | |
| | | |
| | CB agreed that it was an excellent idea and that SN should carry working on how to develop children and young persons' membership. | |
| | | |
| **8** | **Equality and Diversity Open Day, 25 November 2009 – Governors support** | **SN** |
| | | |
| | SN gave an outline of the proposal for the Trust Open Day on 25 November 2009 which will be held in the hospital. | |
| | | |
| | SN saw this as an opportunity for Governors to engage more and also giving a chance to people leaving locally to become involved in their local hospital. SN informed the sub-committee that she will set up PALS stand and will invite visitors to give their feedback by | |

| | | |
|---|---|---|
| | using the new Patient Experience Tracker. | |
| | | |
| | SN handed out a paper listing community groups, which represent support for Equality and Diversity that will hold stalls at the open day.<br>SN requested Governor support on this day.<br>SG and CB agreed to attend in the morning of 25th November, in the Information Zone.<br>SN also plans to demonstrate the Patient Experience Tracker in the M-PALS reception area. | |
| | | |
| **9** | **Communications** | |
| | | |
| **9.1** | **Open Day 2010** | **MA** |
| | | |
| | MA informed the sub-committee that this year's Open Day held on 9 May attracted more than 1,500 visitors and that out of those visitors who gave their feedback 88% would recommend the Open Day to their friends and family. It was a very successful event. | |
| | | |
| | MA informed the sub-committee that the Trust has some informal discussions with the Royal Marsden and Royal Brompton hospitals, to get them involved as partners in Open Day 2010 which will be held on 8 May from 11-3pm. | |
| | | |
| | MA then indicated that aim of the Open Day will be to market the Trust to its members and local residents, develop communication between Council of Governors and the Trust members, promote health and wellbeing, address issues of public concern, foster partnership working and improve staff morale. | |
| | | |
| | MA estimated that 2010 Open Day should cost around the same amount as it did in 2009, which is £15,000 and would be funded by the Council of Governors. The sub-committee supported the funding of 2010 Open Day. | |
| | | |
| | CB suggested that it would be a good idea to get somebody interesting to open the day. | |
| | | |
| | JS suggested that the Trust get somebody from the Chelsea FC. The sub-committee thought it might be a good idea. | |
| | **To propose funding of Open Day 2010 to Council of Governors** | **MA** |
| | | |
| **9.2** | **Evaluation of Annual Members' Meeting 2009** | **MA** |
| | | |
| | MA presented a feedback report noting that 53% of members attending rated the Annual Members' Meeting as excellent and 47% as good. The members also rated as excellent the content of the presentations and the 'Your Hospital Visit' DVD. Also members highly rated the question relating to opportunity for questions and if the Annual Members' Meeting improved their opinion of the hospital. | |

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| **10** | **Membership Report – period ended 31 October 2009** | **SN** |
| | | |
| | SN presented the membership report to the sub-committee and noted that in terms of membership the number has gone down. SN explained that this was due to people changing constituencies. | |
| | | |
| | CM pointed out that the Trust still is finding it difficult to keep the membership number steady considering that still there are more members leaving than joining in. | |
| | | |
| | SN was asked how many people had been recruited by the recruiters in the membership week. SN said approximately 300. | |
| | | |
| **11** | **Any other business** | **CB** |
| | | |
| | ***Date of next meeting*** | |
| | The next meeting will be held on Tuesday, 20 January 2010 at 4pm. | |
| | | |

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Council of Governors Meeting, December 2009

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| **AGENDA ITEM NO.** | 4.3.2/Dec/09 |
| **PAPER** | Council of Governors Membership Report |
| **AUTHOR** | Sian Nelson, Membership and Engagement Manager |
| **LEAD** | Prof. Sir Christopher Edwards, Chairman |
| **EXECUTIVE SUMMARY** | This paper reports on the membership numbers for the Trust which currently has a total membership of 15.466. An update on the recent elections to the Council of Governors is given. |
| **DECISION/ ACTION** | For information |

# Council of Governors Membership Report

## 1. Introduction

This paper sets out the current membership of Chelsea and Westminster Hospital Foundation Trust; the recent election process and opportunities to increase membership in the future.

## 2. Member Constituencies

There are three Member Constituencies, Patient, Public and Staff. Membership for each constituency is illustrated in Table 1. The information in this report was updated on 12 November 2009.

| Constituency | Members | Affiliate members | Total | Percentage |
|---|---|---|---|---|
| Staff | 3,053 | 0 | 3,053 | 20 |
| Patient | 5,998 | 1 | 5,999 | 39 |
| Public | 6,134 | 239 | 6,373 | 41 |
| **Total** | **15,217** | **249** | **15,466** | |

***Table 1: Membership***

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

### 2.1 Patient Constituency

Patient membership for 2009/10 is currently at 5,998. The Trust aims for growth of 5% in 2009/10, hence a further 355 new patient members will be required to achieve our target. The number of patient members who have left currently stands at 409. The reasons for members leaving is generally either because of change of address or death.

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

| Age (years) | |
|---|---|
| 0-21 | 67 |
| 22-40 | 886 |
| 41-65 | 1,544 |
| 66+ | 642 |
| Unknown | 2,861 |

***Table 2: Patient membership by age range***

### 2.2 Public Constituency

The Trust's target is to maintain the current numbers of members in the public constituency in 2009/10. Currently we have 6,134 public members and therefore we aim to recruit a further 238 members by March 2010. To date there have been 155 new members this year compared to 195 for 2008/09.

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

| AGE | 0-21 | 22-40 | 41-65 | 66+ | U/K* | TOTAL |
|---|---|---|---|---|---|---|
| H&F1 | 12 | 127 | 231 | 125 | 78 | 573 |
| H&F2 | 12 | 201 | 380 | 252 | 141 | 986 |
| K&C1 | 19 | 113 | 223 | 126 | 73 | 554 |
| K&C2 | 11 | 260 | 621 | 749 | 257 | 1,898 |
| Wandsworth area 1 | 1 | 85 | 148 | 104 | 31 | 369 |
| Wandsworth area 2 | 10 | 176 | 274 | 206 | 69 | 735 |
| Westminster area 1 | 4 | 66 | 172 | 158 | 65 | 74 |
| Westminster area 2 | 4 | 76 | 184 | 215 | 74 | 553 |

**Key**
H&F 1 = Hammersmith and Fulham area 1
H&F 2 = Hammersmith and Fulham area 2
K&C 1 = Kensington and Chelsea area 1
K&C 2 = Kensington and Chelsea area 2
U/K = Unknown age

| **Ethnicity:** | |
|---|---|
| White | 4,373 |
| Mixed | 245 |
| Asian | 337 |
| Black | 288 |
| Other | 298 |
| **Socio-economic groupings** | |
| ABC1 | 5,302 |
| C2 | 4 |
| D | 0 |
| E | 813 |
| **Gender analysis** | |
| Male | 2,431 |
| Female | 3,660 |

***Table 3: Analysis of Public membership***

## 2.3 Staff Constituency

Staff membership has been updated to include all staff (deducting those who opt out, 15 staff). Table 4 shows staff members numbers were 487 as of the start of 1st April 2009. However, these were staff who applied to become members before the 'opt out' system was in place. The Human Resources department has reviewed all staff data, and the current staff membership is up to date as of 20th October 2009.

| **Staff constituency** | |
|---|---|
| As at start April 1st 2009 | 487 (prior to 'opt-out' system) |
| New Members | 2,567 |
| Members leaving | 1 |
| At November 12th 2009 | 3,053 |

***Table 4: Staff Constituency***

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

## 3. Council of Governors Elections

The Governor elections closed on 25 September 09. A total of 15 seats were available for re-election in all three Member Constituencies. All seven patient representative seats were filled, all five staff category seats were filled; and one public representative seat was filled. The seats in Kensington and Chelsea Area 1, Hammersmith & Fulham Area 2 and Wandsworth Area 2 remain open.

### 3.1 Patient Constituency

7 seats were available and 14 nominees contested these seats. 7 patient representatives have been successfully appointed on Monday 23rd November and received Governor Induction on 24th November 2009.

### 3.2 Public Constituency

Three seats were available in three separate boroughs. These are shown in Table 5 below. The Governor who had represented Hammersmith & Fulham Area 2 for the past three years has been re-elected by her constituency.
The seats in Kensington and Chelsea Area 1, Hammersmith & Fulham Area 1 and Wandsworth Area 2 remain open.

| **Public** | Hammersmith & Fulham Area 2 | Kensington & Chelsea Area 1 | Wandsworth Area 2 |
|---|---|---|---|
| Seats available | 1 | 1 | 1 |
| Nominees | 2 | 0 | 0 |

***Table 5: Public Constituency***

### 3.3 Staff Constituency

Five staff seats were available and successfully filled. A total of 8 staff nominees had contested the seats. The staff groups are shown in Table 6 below

| Staff | Contracted | Management | Medical & Dental | Support, Administrative & Clerical | Allied Health, Professionals, Scientific & Technical |
|---|---|---|---|---|---|
| Seats available | 1 | 1 | 1 | 1 | 1 |
| Nominees | 1 | 2 | 1 | 1 | 3 |

***Table 6: Staff Constituency***

The following constituencies were uncontested:
Staff – Contracted
Staff – Medical & Dental
Staff – Support, Administrative & Clerical

The results have been posted on the Trust internet. All candidates successful or not have been informed. Formal Governor Induction was held on Tuesday 24th November and will be ongoing.

## 4. Appointed Governors

Rosie Glazebrook was nominated by the NHS Hammersmith and Fulham as their representative to the Council of Governors. A welcome letter has been sent to her.

## 5. Annual Work Plan

The new Membership and Engagement Manager has developed an annual work plan in order that the Member's Council continue to achieve an increase in membership. This has been presented to the Council of Governors and was approved in September 2009.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Council of Governors Meeting, 3 December 2009

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| **AGENDA ITEM NO.** | 4.3.3/Dec/09 |
| **PAPER** | Membership Development and Communications Strategy Work Plan 2009/10 for the Council of Governors |
| **AUTHOR** | Sian Nelson, Membership and Engagement Manager |
| **LEAD** | Sir Christopher Edwards, Chairman |
| **SUMMARY** | This paper outlines the direction for the growth and development of the Council of Governors and the constituencies they represent |
| **DECISION/ ACTION** | The Council of Governors is requested to review the work plan |

# Membership Development and Communications Strategy Work Plan 2009/10 for the Council of Governors

## 1. Introduction

The Council of Governors Membership Development and Communications Work Plan for September 2009-April 2010 outlines the direction for the growth and development of the Council of Governors and the constituencies they represent. In response to the Membership Development and Communications Strategy (June 2009) this document forms a framework to demonstrate existing membership activities and presents the plan of activities to ensure that growth, vibrancy and motivation of the council of governance is encouraged through 2010 and beyond.

## 2. Background

The work plan is formulated to respond to and meet the objectives of the Membership Development and Communications Strategy (June 2009). The strategy focuses on increasing membership and ensuring a seamless system is in place to support this.

The Trust and the Council of Governors must ensure that it reflects the diverse communities it represents. Therefore working alongside the Equality and Diversity Group will assure the Council of governances activities are vigorous in delivering equality to its membership.
The work plan will ensure we meet agreed objectives within an achievable framework; both practically and within a realistic time frame. It delivers accountability and aims to distribute responsibilities collectively and individually to the Council of Governors.

### 2.1 Current engagement with membership

Chelsea and Westminster Hospital Foundation Trust inform members about the activities of the Trust and engage their interest and support in a number of ways:

- Chelsea and Westminster Hospital Annual Open day for Foundation Trust members.
- Biannual membership mailings, including the Trust News
- Two recruitment weeks for potential new Trust members.
- Quarterly Council of Governor meetings
- Quarterly Council of Governors Communications Sub-Communications meetings

## 3.0 Progress to date

The Membership and Engagement Manager has been appointed and responsibilities within the role are to create stronger links between the Council of Governance, Foundation Trust Members, staff, and patients.

### 3.1 Rebranding of PALS

The Patient Advice and Liaison Service (PALS) has expanded its responsibilities to collaborate with and support the Council of Governors and its Members. Therefore the PALS title has changed to Membership – Patient Advice and Liaison Service (M-PALS). M-PALS officers will take an active role in engaging with patients and the public to encourage membership and promote membership events. The team will receive training to ensure that correct information is communicated to existing and potential members.

### 3.2 M-PALS comments cards

M-PALS have re-designed its comment cards which are now more user friendly. The cards will be distributed to every clinical area in the Trust (with the exception of maternity services which has a specific maternity design). This will encourage patient feedback so that themes can be registered at M-PALS and fed back to the clinical environments and the Patient Experience Improvement Group.

### 3.3 Improved collaboration with Chelsea and Westminster Hospital Health Care Charity

The Membership and Engagement Manager has developed an association with Chelsea and Westminster Hospital Health Care Charity. The charity has agreed to allow a Members stand at the Duathlon event in September 2009. This will provide the council of governance the opportunity to enhance its profile and engage and recruit members from a wider community, especially those within the age group 16-40 years.

The charity has won the bid of 'charity of the year' with Sainsbury's supermarket. The Cromwell Road and Fulham Road branches will support the Chelsea and Westminster Health Care Charity. The charity has agreed to erect a member's stand at the Cromwell Road branch. Again this will help us reach a wider community group, specifically families and the younger age group less than forty years old.

### 3.4 Annual Members' Meeting

The Annual Member's Meeting and Council of Governors Meeting will be held on the 17th of September 2009. Leading to this will be a recruitment campaign held inside the Information Zone. From Monday to Friday 'patient experience' volunteers and M-PALS Officers will engage with the public, staff and patients to explain about the elections, becoming a Foundation Trust Member and how to stand for election. Those persons wishing to stand for election can attend a workshop session (held Mon-Fri 12-2pm) with a Council Governor, who will discuss the role and explain the application process.

### 3.5 Council of Governors Elections

The Council of Governors election is fixed for November 2009. Prior to this there will be a process of electoral preparations. Electoral mail will be sent to Trust members in each constituency. We will use this mailing opportunity to send other relevant information regarding the Trust.

The Equality and Diversity group plan an open day to celebrate its single equality scheme. There will be a wide range of demonstrations and exhibitions from all areas of representations, such as disability groups, gender, age groups etc.

This will create an opportunity for the Council of Governors to support Equality and Diversity; to establish links with diverse groups, and to exhibit the importance that

Equality and Diversity plays in the Council of Governors and its quest for representation within its membership.

### 3.6 Governors Induction and Training

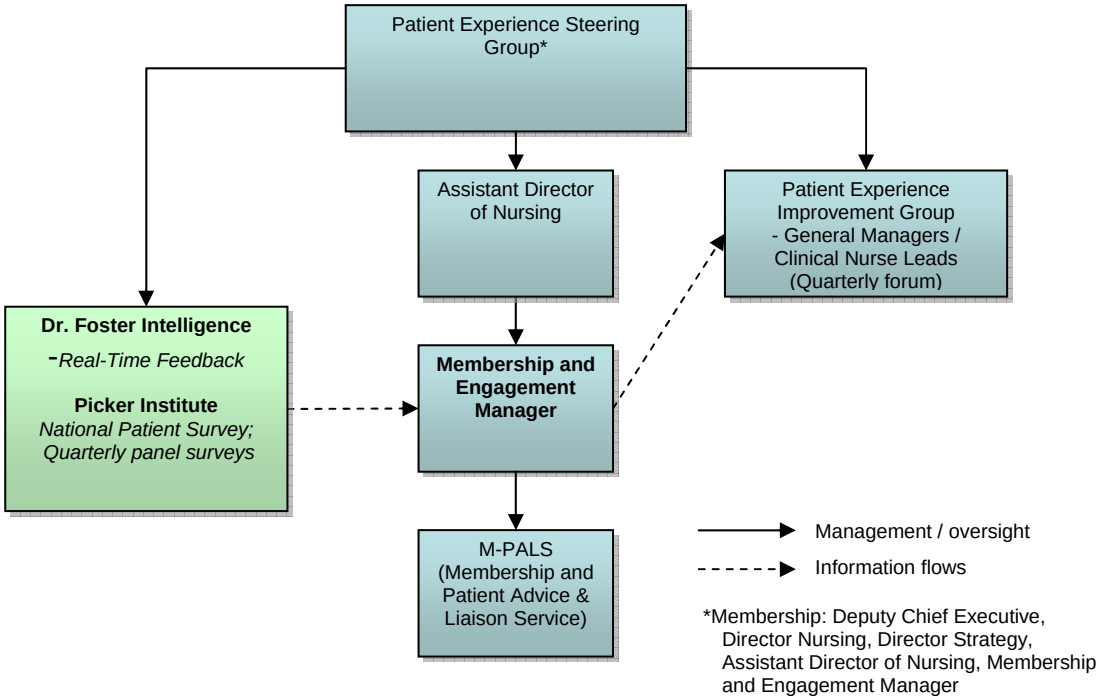
Induction and training for new or existing Council of Governors will be developed and external groups will be sought to establish this. The training will comprise of modules relating to issues around health, its affects on society and on individuals, and how to develop this knowledge further by identifying focus groups to develop projects aimed at improving services.

### 3.7 Improving the patient experience

Improving the patient experience is of prime importance to the care we deliver at Chelsea and Westminster Hospital Foundation Trust. The Membership and Engagement Manager coordinates patient feedback to improve quality of services. Chelsea and Westminster Hospital participates in the national survey programme, and has implemented a unique patient feedback questionnaire, called a patient experience tracker (PET). The hand-held electronic questionnaire captures the patients experience before leaving hospital. The results are analysed immediately, which gives staff the opportunity to evaluate and improve services.
In synchronisation, M-PALS comment cards are circulated throughout the Trust. The comments are registered at M-PALS; themes of this feedback are recorded and fed back to the relevant clinical areas.

Management of feedback is coordinated across the hospital. The Patient Experience Steering Group (PESG) has been established to direct the Trust's strategy and objectives of the patient experience. The Patient Experience Improvement Group (PEIG) has been developed to deliver the patient experience strategy and coordinates the ongoing management of feedback. This structure is outlined in Figure 1. The PEIG actively track and take actions in response to feedback.

Figure 1. Managing patient feedback




**4.0 Ideas/proposals**
Potential activities will be put forth to the Council of Governors.

**4.1 Increasing activities with patient forums**
There are currently numerous patient forums set up within the hospital that represent specific clinical areas of care (Table 1 below) Linking the Council of Governors with a patient forum will enable the governor to represent patients and connect with activities within the Trust. Patient forums will be presented at Council of Governors meetings and those governors who wish to become involved with a specific forum will be introduced to that patient forum group.

Table 1. Trust wide patient forums

| | | | | |
|---|---|---|---|---|
| Maternity Services Liaison committee (MSLC) | HIV forum | Heart failure | Breastfeeding Forum | Policy and Procedure forum (inactive at present) |
| Bariatric forum | Intensive Care Unit forum | Rheumatoid arthritis forum | Menopause forum | Joint Research Committee |
| Children's, families and Young Persons forum | Research Strategy Group | Patient Environment Action Teams (PEAT) | | |

**4.2 Annual Plan**
In previous years there has been limited involvement of the Council of Governors in development of the Trust's Annual Plan.
Development of the Annual Plan is an opportunity to involve the Council of Governors in shaping the strategic direction of the Trust and would be suitable because the role of Governors should be to add value to strategic, not operational issues.

Specifics should be discussed with the Trust Board, but the key is to involve the Council of Governance at an earlier stage where they can genuinely influence the Trust's strategic direction – not inviting them to attend feedback sessions after the strategy has been decided.

There is also scope to involve and engage the wider Foundation Trust membership – for example by asking members to vote on their top three priorities from a list of perhaps 5-10 and/or by running sessions where members can meet their representatives on the Council of Governance and give their views on the Trust's strategy.

**4.3 Increasing events**
Increasing events will ensure we engage with our members and create a more beneficial and interactive relationship. Collaboration with other events in the Trust will be advantageous; helping the Council of governance to network with the Trust and reaching to wider social groups that we may otherwise not have contact with. Sharing of events will also ease costs.

**4.4 improved collaboration with Health Care Charity**
Chelsea and Westminster Hospital Health Care Charity support various community projects throughout London and are pro-active with health promotion. This reflects positively on the Trust. By association, the Council of governance can reach to wider and diverse groups in the community that we may not otherwise have access to. Involvement with the charities events will lead to enhanced publicity of the Council of Governors and encourage greater numbers of Foundation Trust members.

**5. Summary**
The Annual Work Plan 2009/10 for the Council of Governors is our opportunity as a Trust to outline the current and potential contribution of both Governors and our Membership to improving the services we deliver at Chelsea and Westminster Hospital. The plan will be reviewed at each meeting of the Council of governance Sub-Communication meeting and a quarterly progress report will be presented to the Council of governance meeting.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Council of Governors Meeting, 3 December 2009

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|---|---|
| **AGENDA ITEM NO.** | 4.4/Dec/09 |
| **PAPER** | Term of office of the Chairman* |
| **AUTHOR** | Vida Djelic, Interim FT Secretary |
| **LEAD** | Charlie Wilson, Non-Executive Director and Vice Chairman of the Board of Directors |
| **EXECUTIVE SUMMARY** | This paper gives an account of an issue relating to the term office of the Chairman which was not determined by the Council of Governors as required by the Constitution 12.7.1 |
| **DECISION/ ACTION** | The Council is asked to agree the term of office of the Chairman. |

## 1. Introduction

This paper clarifies the term of the Chairman's office.

## 2. Background

The Council of Governors at its General meeting on 24th July 2007, on the recommendation of its nomination committee, approved the appointment of the Chairman commencing 1st November 2007. However, a term of office was not determined as required by the Constitution 12.7.1.

12.7.1. The Chairman and the non-executive Directors are to be appointed for a period of office in accordance with the terms and conditions of office, including remuneration and allowances, decided by the Council of Governors at a General Meeting. Any re-appointment of a non-executive Director by the Council of Governors shall be subject to a satisfactory appraisal carried out in accordance with procedures which the Board of Directors has approved.

## 3. Term of office

The Code of Governance states:

**'C.2.2** Non-executive directors, including the chairman, should be appointed by the board of governors for specified terms subject to re-appointment thereafter at intervals of no more than three years and to the 2003 Act provisions relating to the removal of a director. The chairman should confirm to governors that, following formal performance evaluation, the performance of the individual proposed for re-election continues to be effective and to demonstrate commitment to the role.'

## 4. Action

The Council of Governors is asked to agree that in line with the Code of Governance the term of office of the Chairman will be three years.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Council of Governors Meeting, 3 December 2009

| | |
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| **AGENDA ITEM NO.** | 4.5/Dec/09 |
| **PAPER** | Communications Sub -Committee Terms of Reference* |
| **AUTHOR** | Catherine Mooney, Director of Governance and Corporate Affairs |
| **LEAD** | Catherine Mooney, Director of Governance and Corporate Affairs |
| **EXECUTIVE SUMMARY** | A revision to the terms of reference were agreed at the Council of Governors in June 2009. Further changes to the terms of reference are proposed in the attached. The main ones are:<br>• The committee to be called the Council of Governors Membership Development Sub-Committee, rather than the Communications Sub Committee, which more accurately reflects its focus.<br>• To be supported by the Foundation Trust Secretary rather than the Membership and Engagement Manager, as it is a sub-committee of the Council of Governors.<br>• To clarify the responsibility for the work plan.<br>These amendments were agreed by the sub-Committee at its meeting in Sept 09. |
| **DECISION/ ACTION** | The Council is asked to agree the revisions to the terms of reference of the Communications Sub-Committee. |

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Council of Governors M**embership Development Sub-Committee**, Sub-Committee

## Terms of Reference

**1.0 Authority**

1.1 The Council of Governors Membership Development Sub-Committee is constituted as a Sub- Committee of the Council of Governors to assist the Council of Governors to implement and develop the Trust's Membership Development and Communications Strategy as decided by the Council of Governors and to facilitate communication between the Trust's members and the Council of Governors and between the Trust and the public.

1.2 Its terms of reference shall be as set out below and shall not be amended, revoked or replaced except by a resolution passed at a general meeting of the Council of Governors.

**2.0 Role**

2.1 The Council of Governors Membership Development Sub-Committee shall be responsible for advice and support on:

a) the production of material to recruit new members for the Trust and to engage members in the work of the Trust
b) the content of the material on the hospital's website and on the LCD screen and touch terminals in the Information Zone
c) using the Council of Governors budget in the implementation and development of the Trust's Membership Development and Communications Strategy
d) ensuring that hospital and Trust material is issued in plain English, free of jargon and unexplained sets of initials.

2.2 The Council of Governors shall not delegate any of its powers to the Sub-Committee and the Sub-Committee shall not exercise any of the powers of the Council of Governors..

**2.0 Membership of the Sub-Committee**

2.1 The Sub-committee shall comprise elected Governors from the public, patient and staff constituencies who are concerned with the implementation and

development of the Trust's Membership Development and Communications Strategy.

2.2 The following members of the Trust's staff are invited to attend:

a) The Membership & Engagement Manager
b) The Head of Communications
c) Equality & Diversity Manager
d) GP liaison Manager (as required)
e) The FT Secretary
f) The Director of Nursing
g) The Director of Governance and Corporate Affairs

## 3.0 Frequency of Meetings

3.1 The Sub-Committee shall meet bi-monthly and report to the Council of Governors after each meeting.

## 4.0 Planning and Administration of Meetings

4.1 At each meeting of the Sub-Committee immediately following the Annual Members' Meeting, the Sub-Committee shall elect from its membership, a Governor to serve as Chairman until the next Annual Members' Meeting.

4.2 Where a casual vacancy arises because the Chairman is absent or unable to discharge his or her duties, the Sub-Committee shall elect from its membership, a Governor to serve as Acting Chairman until the next meeting.

4.3 The Membership and Engagement Manager will support the planning of the Sub-Committee

4.4 The Foundation Trust Secretary will act as secretary to the Sub-Committee.

4.5 The work plan will be agreed by the Sub-Committee for ratification by the Council of Governors.

## 5.0 Review

5.1 The terms of reference of the committee shall be reviewed by the Council of Governors at least annually.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Council of Governors Membership Development Sub-Committee

Deleted: Communications

## Terms of Reference

### 1.0 Authority

1.1 The Council of Governors Membership Development Sub-Committee is constituted as a Sub- Committee of the Council of Governors to assist the Council of Governors to implement and develop the Trust's Membership Development and Communications Strategy as decided by the Council of Governors and to facilitate communication between the Trust's members and the Council of Governors and between the Trust and the public.

Deleted: Communications

1.2 Its terms of reference shall be as set out below and shall not be amended, revoked or replaced except by a resolution passed at a general meeting of the Council of Governors.

Deleted: Members' Council

### 2.0 Role

2.1 The Council of Governors Membership Development Sub-Committee shall be responsible for advice and support on:

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a) the production of material to recruit new members for the Trust and to engage members in the work of the Trust
b) the content of the material on the hospital's website and on the LCD screen and touch terminals in the Information Zone
c) using the Council of Governors budget in the implementation and development of the Trust's Membership Development and Communications Strategy
d) ensuring that hospital and Trust material is issued in plain English, free of jargon and unexplained sets of initials.

2.2 The Council of Governors shall not delegate any of its powers to the Sub-Committee and the Sub-Committee shall not exercise any of the powers of the Council of Governors.

Deleted: Members' Council

### 2.0 Membership of the Sub-Committee

2.1 The Sub-Committee shall comprise elected Governors from the public, patient and staff constituencies who are concerned with the implementation and development of the Trust's Membership Development and Communications Strategy.

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2.2 The following members of the Trust's staff are invited to attend:

a) The Membership & Engagement Manager
b) The Head of Communications
c) Equality & Diversity Manager
d) GP liaison Manager (as required)
e) The FT Secretary
f) The Director of Nursing
g) The Director of Governance and Corporate Affairs

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3.1 The Sub-Committee shall meet bi-monthly and report to the Council of Governors after each meeting.

## 4.0 Planning and Administration of Meetings

4.1 At each meeting of the Sub-Committee immediately following the Annual Members' Meeting, the Sub-Committee shall elect from its membership, a Governor to serve as Chairperson until the next Annual Members' Meeting.

4.2 Where a casual vacancy arises because the Chairman is absent or unable to discharge his or her duties, the Sub-Committee shall elect from its membership, a Governor to serve as Acting Chairman until the next meeting.

4.3 The Membership and Engagement Manager will support the planning of the Sub-Committee.

4.4 The Foundation Trust Secretary will act as secretary to the Sub-Committee.

4.5 The work plan will be agreed by the Sub-Committee and ratified by the Council of Governors.

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## 5.0 Review

5.1 The terms of reference of the Sub-Committee shall be reviewed by the Council of Governors at least annually.

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Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Council of Governors Meeting, 3 December 2009

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| **AGENDA ITEM NO.** | 4.6/Dec/09 |
| **PAPER** | Agreement on meeting dates and time |
| **AUTHOR** | Vida Djelic, Interim FT Secretary |
| **LEAD** | Prof. Sir Christopher Edwards, Chairman |
| **EXECUTIVE SUMMARY** | This paper details the proposed schedule of Council of Governors meeting dates for 2010.<br><br>There have been discussions previously on the time of the meetings. The Council of Governors agreed that 4.30pm was the preferred time. The results of that survey were that eight Governors were neutral, one did not prefer 4.30pm and four did not prefer 6.30pm. However, there are now 15 new governors and it is proposed that the Council of Governors are re-surveyed as to the preferred time, with the options being 4.30pm and 6pm. |
| **DECISION/ ACTION** | To Council is asked to note the dates and that a survey will be conducted. |

**Council of Governors meeting dates 2010:**

- 11 February
- 15 April
- 21 July
- 14 October

# Council of Governors Meeting, 3 December 2009

| | |
|---|---|
| **AGENDA ITEM NO.** | 4.7/Dec/09 |
| **PAPER** | Council of Governors Funding Report* |
| **AUTHOR** | Part A - Vida Djelic, Interim FT Secretary<br>Part B - Matt Akid, Head of Communications |
| **LEAD** | Matt Akid, Head of Communications |
| **SUMMARY** | This paper provides an overview of the funds spent to date from the Council of Governors budget on the Open Day and other membership related activity. |
| **DECISION/ ACTION** | The Council is asked to note the funding report and to confirm funding of Open Day 2010. |

# Council of Governors Funding Report

## 1.0 Background

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

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

## 2.0 Update

At the last meeting of the Council of Governors it was agreed that £12,800 would be spent on the following:

- Website optimisation - £7,000
- Staff training - £4,000
- New technology - £1,800

## 3.0 Funding Overview

Of the £100,500 circa £59k has been spent. In addition to that circa £15k has been agreed but not realised yet which leaves an unallocated amount of circa £50k in the budget for the remainder of the financial year (March 2010).

| Item | Estimates (excl VAT) |
|---|---|
| Annual budget 2009-2010 | 100,500 |
| Accrued 08/09 for approved expenditure | 15,646 |
| Information Zone seating, screen & wing art | -16,236 |
| Information Zone Security Kiosk move | -305 |
| Recruitment Campaign for Open Day | -2,574 |
| Open Day | -12,334 |
| **Residual Budget 09-10** | **84,697** |
| **Less Agreed Allocation** | |
| Information Zone Security Frame to TV, Kiosk move, contingency, Project Management Fees | -3,763 |
| Recruitment Campaign for Annual Members' Meeting | -2,574 |
| Discharge Leaflets | -8,200 |
| Directory of Adult's services | - 19,817 |
| **Unallocated Budget** | **50,344** |

## 4.0 Proposed Items for future Funding

The Trust Open Day 2010 have been put forward for consideration for funding in the future.

**Part B**

**Open Day 2010 – Proposal**

This paper outlines a proposal for the Trust Open Day 2010.

**1. Introduction**

1.1 Since 1995 Chelsea and Westminster Hospital has held 10 Open Days. These events are 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. At its meeting on 19 March 2009 the Members' Council agreed to fund Open Day 2009 at a cost of £15,000.

1.2 This year's Open Day on Saturday 9 May 2009 attracted more than 1,500 visitors, VIPs including local MPs Sir Malcolm Rifkind and Greg Hands, the Mayors of Kensington & Chelsea and Wandsworth, and pop star Sophie Ellis-Bextor who officially opened The Kensington Wing. A total of 37 Trust teams, 7 charities associated with the Trust and 23 partner organisations took part.

1.3 Open Day visitors were invited to give their feedback by using the new Patient Experience Trackers which are now used to gather instant patient feedback in the hospital – 88% of visitors said they would recommend the Open Day to friends and family.

1.4 Open Day 2009 was made possible thanks to funding of the event by the Council of Governors at a cost of £15,000. This was the first year that the Council had supported the Open Day financially.

**2. Aims**

2.1 **Open Day 2010** will be held from **11am-3pm** on **Saturday 8 May**.

2.2 **Aims** of Open Day 2010 are to:

- Market the Trust to Foundation Trust members and local residents
- Develop communication between Members' Council representatives and Foundation Trust members
- Promote health and wellbeing
- Address issues of public concern
- Foster partnership working
- Improve staff morale

2.2.1 Informal discussions have already been held with our neighbours on Fulham Road, the Royal Marsden and Royal Brompton hospitals, to involve them as partners in Open Day 2010. This would demonstrate partnership working with 2 world famous specialist hospitals that, like Chelsea and Westminster were ranked double 'Excellent' in the recent NHS performance ratings.

2.2.2 The involvement of the Royal Marsden and Royal Brompton would also be of interest to patients and could provide an opportunity for collaborative working in terms of using the

Open Day to recruit Foundation Trust members and demonstrate the benefits of Foundation Trust status.

## 3. Implementation

3.1 It is intended to keep the same project structure, as this has worked well in previous years, and Governors would be invited to nominate themselves to sit on the Open Day Steering Group and/or Operational Group:

- **Steering Group** – to provide high level oversight of the Open Day. Membership to include as a minimum the Chief Executive, a Non-Executive Director and a Governor.
- **Operational Group** – to manage planning and implementation of the Open Day. Membership to include a Governor, as well as representatives of Trust charities, directorates and departments in the Trust, and contractors including ISS Mediclean. Group to be chaired by the Trust's Director of Governance & Corporate Affairs, line manager of the Head of Communications who has overall responsibility for project managing the Open Day.

3.2 The Head of Communications will continue to be responsible for project managing the Open Day including publicity, logistics, liaison with Trust staff and partner organisations etc.

## 4. Funding

The Council of Governors provided £15,000 funding for Open Day 2009 which helped make the event possible – the Trust is very grateful for this financial support and would like to ask the Council to agree funding the Open Day 2010 at the same cost.

## 5. Actions for the Council of Governors

The Council of Governors is invited to confirm funding of Open Day 2010 – this request was supported in principle by members of the Council of Governors Communications Sub-Committee at their meeting on 10 November.

**Matt Akid**
**Head of Communications**
**December 2009**

# Delegate Feedback Report

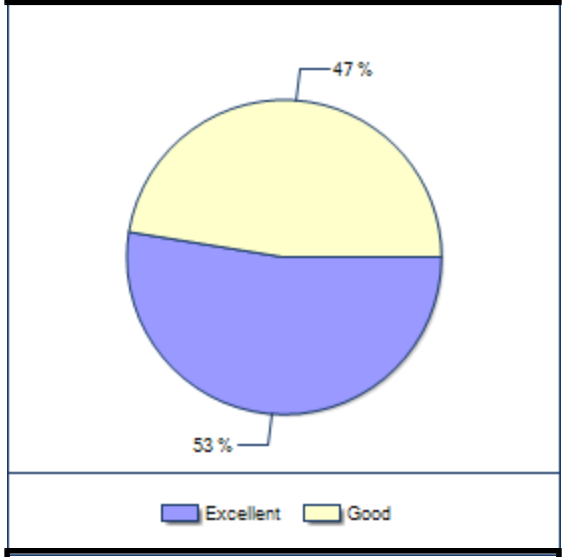
**Period: 17 September 09 to 17 September 09**

**Chelsea and Westminster Hospital AGM**

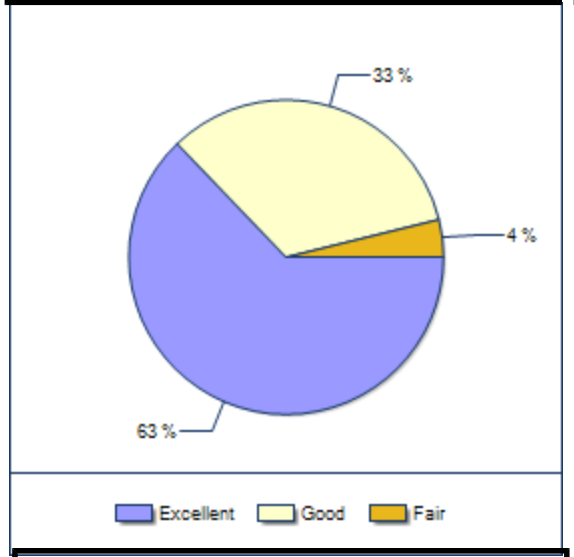
**Question Set: Dr Foster_CWNHS_Annual Meeting_ID74_08092009**

| **Response Volume** | 78 |
|---|---|

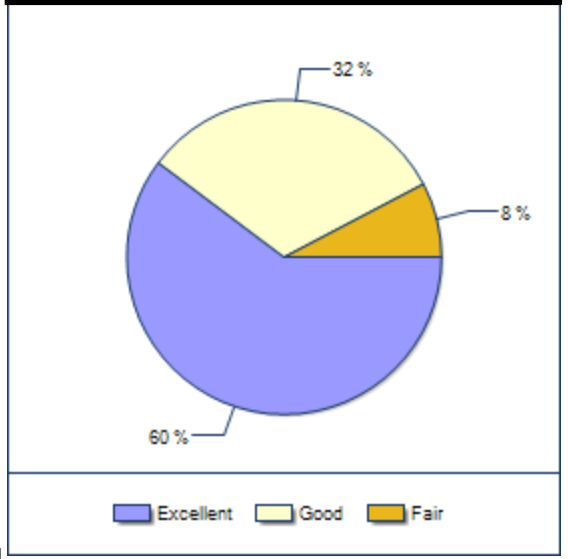
How would you rate the Annual Members' Meeting?



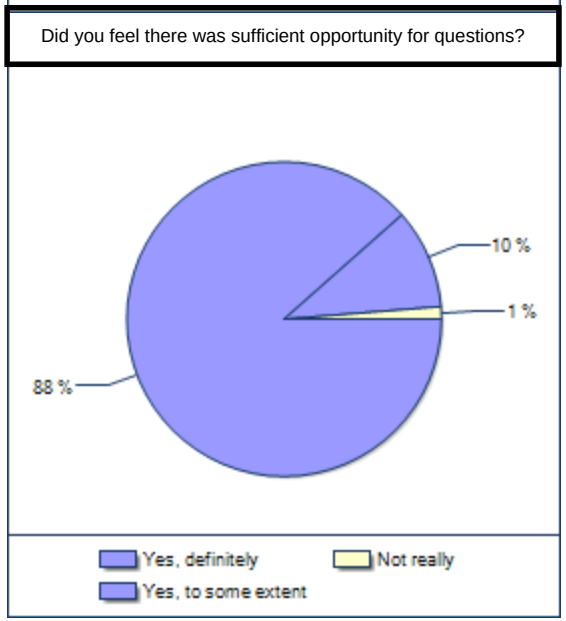

How would you rate the content of the presentations?



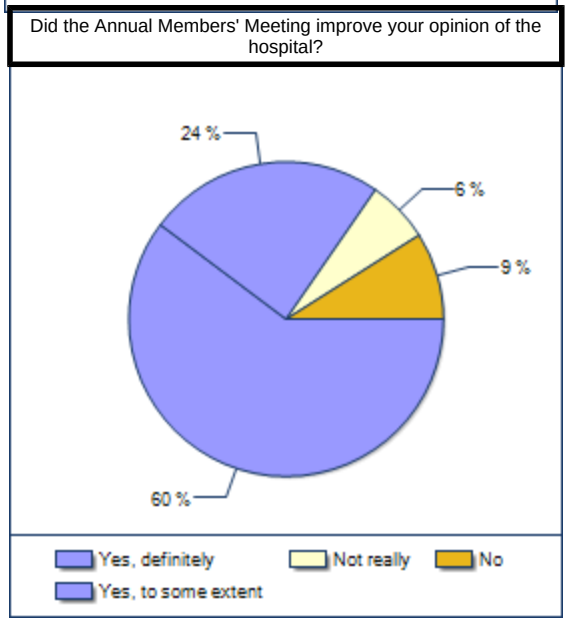

How would you rate the 'Your Hospital Visit' DVD?




Did you feel there was sufficient opportunity for questions?




Did the Annual Members' Meeting improve your opinion of the hospital?



Chelsea and Westminster Hospital NHS
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# Council of Governors Meeting, 3 December 2009

| | |
|---|---|
| **AGENDA ITEM NO.** | 5.1/Dec/09 |
| **PAPER** | Membership of Sub-Committees and Trust Groups |
| **AUTHOR** | Vida Djelic, Interim FT Secretary |
| **LEAD** | Prof. Sir Christopher Edwards, Chairman |
| **SUMMARY** | This paper provides an overview of the membership of Council of Governors sub-committees and Trust groups where governors are encouraged to join.<br><br>The membership and terms of reference of Quality sub-committee are to be agreed at the meeting on 3 December 2009.<br><br>Governors are encouraged to be members of the sub-committees and Trust groups, particularly the Communication sub-committee where two members have left and the Quality group which is new. |
| **DECISION/ ACTION** | The Council is asked to note the paper and to put their nominations forward for vacant places. |

## Council of Governors Sub-Committees

### Council of Governors Agenda Sub-Committee

| |
|---|
| Prof. Sir Christopher Edwards, Chairman |
| Heather Lawrence, Chief Executive |
| Walter Balmford, Patient |
| Brian Gazzard, Staff – Medical and Dental |
| Sandra Smith-Gordon, Public – Kensington and Chelsea 2 |
| Frances Taylor, Local Council - Kensington and Chelsea |
| **In attendance:** |
| Catherine Mooney, Director of Governance and Corporate Affairs |
| Vida Djelic, Interim FT Secretary |

### Council of Governors Communications Sub-Committee

| |
|---|
| Chris Birch, Patient – Chairman |
| June Bennett, Patient |
| Alison Delamare, Staff – Contracted<br>(vacant place) |
| Martin Lewis, Patient |
| Martin Rowell, Patient<br>(vacant place) |
| Sandra Smith-Gordon, Public – Kensington and Chelsea 2 |
| Jim Smith, Patient |
| **In attendance:** |
| Priti Bhatt, Equality and Diversity Manager |
| Andrew MacCallum, Director of Nursing |
| Renae McBride, Communications Manager |
| Catherine Mooney, Director of Governance and Corporate Affairs |
| Sian Nelson, Membership and Engagement Manager |
| Jane Tippett, Assistant, Director of Nursing |
| Vida Djelic, Interim FT Secretary |

## Trust Groups

**Open Day Steering Group**
Governors are invited to nominate themselves for this group.
Membership to include the following:

| |
|---|
| Governor – minimum 1 |
| Chief Executive |
| Non-Executive Director |

**Open Day Operational Group**
Governors are invited to nominate themselves for this group.
Membership to include the following:

| |
|---|
| Chair – Trust's Director of Governance and Corporate Affairs |
| Project Manager – Trust's Head of Communication |
| Governor – minimum 1 |
| Representatives of Trust charities |
| Representatives of Trust directorates/departments |
| Contractors: ISS Mediclean |

**Website Development Steering Group**

| |
|---|
| Chris Birch |
| Mary Symons |
| Governor - vacant place |

**For information**

**Assurance Committee**

| |
|---|
| Governors |
| Christine Blewett |
| Mary Symons |

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Council of Governors Meeting, 3 December 2009

| | |
|---|---|
| **AGENDA ITEM NO.** | 5.2/Dec/09 |
| **PAPER** | Agreement of Annual Cycle of Business |
| **AUTHOR** | Vida Djelic, Interim FT Secretary |
| **LEAD** | Vida Djelic, Interim FT Secretary |
| **SUMMARY** | This paper provides an overview of items for future meetings of Council of Governors. |
| **DECISION/ ACTION** | The Council is asked to note the paper |

# COUNCIL OF GOVERNORS ANNUAL CYCLE OF BUSINESS

| **Standard Agenda Items** | | |
|---|---|---|
| Welcome & Apologies | | |
| Declaration of Interests | | |
| Minutes of Previous Meeting | | |
| Matters Arising | | |
| Chairman's Report (oral) | | |
| Council of Governors Funding Report | | |
| Finance Report | | |
| Performance Report | | |
| Membership Report | | |
| **3 DECEMBER 2009** | **LEAD** | **DEADLINE** |
| Announcement of Election Results | | |
| Administrative business | | |
| **11 FEBRUARY 2010** | | |
| **Theme: Business Planning & Service Development Strategy** | | |
| Discussion of Planning Priorities with Board of Directors and Council of Governors | | |
| **15 APRIL 2010** | | |
| **Theme: Membership & Engagement** | | |
| Membership Communications Sub-Committee Annual Report, including membership & annual work plan 2010/11 | | |
| Quality Sub-Committee Report | | |
| Annual Budget Allocation | | |
| Open Day Preparation | | |
| **21 JULY 2010** | | |
| **Theme: Finance & Governance** | | |
| Presentation of Annual Accounts & Auditors Report[1] | | |
| Report of the Audit Committee[2] | | |
| Appointment of the Auditor[3] | | |

[1] Constitution 17.6
[2] Code F.3.2
[3] Code F.3.5/Constitution 16.4

| | | |
|---|---|---|
| Annual Members' Meeting Preparation | | |
| Constitution Review | | |
| Chair Appraisal | | |
| **14 OCTOBER 2010** | | |
| **Theme: Refreshing the Board of Directors** | | |
| (Re)/Appointments Chair & NEDS<br>CE / CG / RK/ AH / CW | | |

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Council of Governors Meeting, 3 December 2009

| | |
|---|---|
| **AGENDA ITEM NO.** | 5.3/Dec/09 |
| **PAPER** | Finance Report – October 2009 |
| **AUTHOR** | Kelda Alleyne, Deputy Director of Finance |
| **LEAD** | Lorraine Bewes, Executive Director of Finance |
| **EXECUTIVE SUMMARY** | The reported financial position for the Trust as at 31st October 2009 is a surplus of £4.3m, which is £0.53m behind plan.<br><br>Cash flow is £4.9m ahead of the plan. Early payments of £8.3m from some PCTs (mainly Kensington & Chelsea PCT) have contributed to this position.<br><br>The forecast is that the financial plan will be achieved with a small surplus of £0.21m as illustrated in paragraph 2.2 below.<br><br>A recovery plan for each directorate was mandated with the aim of pulling back the forecast EBITDA shortfall by £2.7m. This will be monitored on a monthly basis. |
| **DECISION/ ACTION** | The Council of Governors is asked to note the financial position as at 31st October 2009 and the updates in this report. |

**Financial Summary to October 2009**

## 1. Introduction

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

## 2. Overall Financial Position (Form F1)

2.1 The YTD I&E position is a deficit of £0.53m compared to plan as illustrated below:

| | Period to 31 October | | | Full Year Forecast | | |
|---|---|---|---|---|---|---|
| | Budget £m | Actual £m | Variance £m | Budget £m | Actual £m | Variance £m |
| Income | 176.88 | 179.35 | 2.48 | 303.61 | 306.99 | 3.37 |
| Expenditure | 160.71 | 165.33 | -4.63 | 277.37 | 283.42 | -6.05 |
| EBITDA | 16.17 | 14.02 | -2.15 | 26.24 | 23.57 | -2.68 |
| EBITDA Margin % | 9.1% | 7.8% | | 8.6% | 7.7% | |
| Interest, Dividends & Depreciation | 11.38 | 9.77 | 1.62 | 19.84 | 16.95 | 2.89 |
| Surplus / Deficit (-ve) | 4.79 | 4.25 | -0.53 | 6.40 | 6.61 | 0.21 |

2.2 The CIP target for the period to October is £5.9m. It has been assessed that £5.17m (88%) has been achieved against this target. The full year forecast achievement is that 89% of the target will be achieved, with a full year shortfall of £1.1m. The forecast assumes that the high-risk CIP in central procurement will not be achieved by year end.

## 3 Income

### 3.1 NHS Clinical Contract Income

NHS Income from PCTs was under plan in July (£0.11m adverse). The cumulative position for the seven months in 2009/10 is ahead of plan by £0.89m, of which £0.19m relates to in year activity over performance and £0.70m reflecting a prior year income benefit.

The performance against planned contract income by point of delivery is shown in the following table, which indicates that activity for the YTD at 944,766 is only 0.6% ahead of plan. Planned activity continues to under-perform, however this is being mitigated by high emergency and Burns Critical Care activity.

| Activity Type | Currency | Activity Actual | Activity variance % | Surplus / (Deficit) October 2009 |
|---|---|---|---|---|
| Elective | Spells/FCE's | 3,299 | -1.1% | 39.7 |
| Planned Same day | Spells/FCE's | 12,495 | -3.8% | - 371.4 |
| Regular days | Spells/FCE's | 4,364 | -14.5% | - 13.0 |
| Non Elective | Spells/FCE's | 20,238 | 10.2% | 461.1 |
| Critical Care – Adult | Bed days | 1,621 | 0.2% | 62.7 |
| Critical Care – Burns | Bed days | 358 | 473.4% | 668.6 |
| Critical Care - NICU/SCBU | Cot days | 6,576 | -3.9% | - 397.5 |
| A&E attendances | Attendances | 59,225 | 0.4% | 20.0 |
| Outpatients(incls procedures and virtual clinics) | Attendances | 251,876 | 0.8% | 48.6 |
| Excess Bed Days | Excess bed days | 11,088 | 33.9% | 874.8 |
| Other | Tests and Provisions, Critical care correction | 573,625 | 0.0% | - 1,320.9 |
| **Total for 2009/10** | | **944,766** | **0.6%** | **72.8** |
| Prior Year | | 3,491 | | 885.8 |
| **Grand Total** | | **948,257** | **0.6%** | **958.6** |

* RDA = Regular Day Attenders
* PSD = Procedures same day

### 3.2 Non Contract Income

All other income outside of NHS Clinical Income is reported here and is represented in the table below.

| Description | Budget Year to Date to M7 £000s | Actual Year to Date to M7 £000s | Surplus/(Deficit) Year to Date to M7 £000s | Budget In-Month M7 £000s | Actual In-Month M7 £000s | Surplus/(Deficit) In-Month M7 £000s |
|---|---|---|---|---|---|---|
| Other NHS Non Tariff Income (incl. charges to other NHS orgs) | 353 | 582 | 229 | 17 | 137 | 120 |
| Other Non-NHS Clinical revenue (incl. overseas visitors and royalties) | 593 | 859 | 266 | 85 | 103 | 18 |
| Private Patients | 5,345 | 4,451 | (894) | 841 | 681 | (160) |
| Research & Development | 1,930 | 2,134 | 204 | 442 | 471 | 29 |
| Education & Training | 13,918 | 14,430 | 512 | 1,988 | 2,256 | 268 |
| Misc Other Operating Income (incl. salary recharges, car parking, catering, etc.) | 5,866 | 7,131 | 1,265 | 843 | 1,035 | 192 |
| **Total** | **28,005** | **29,587** | **1,582** | **4,216** | **4,683** | **467** |

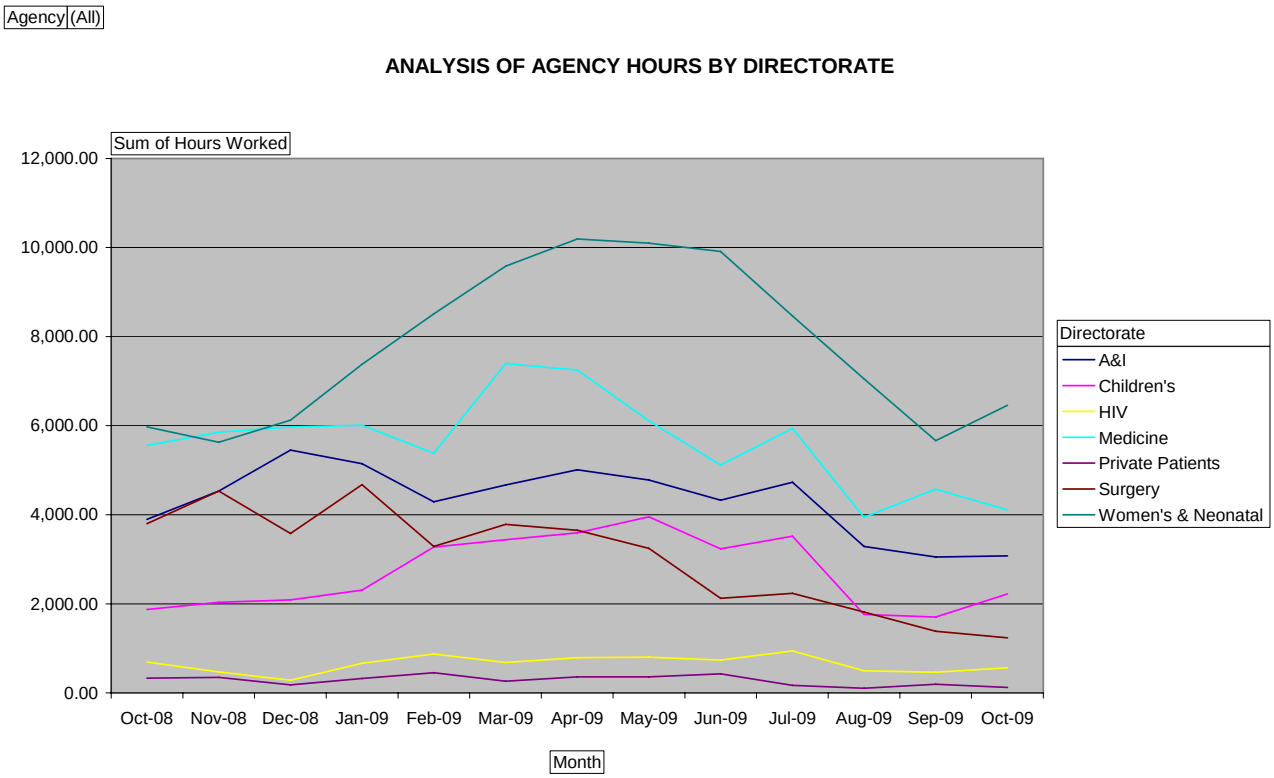
## 4 Expenditure

4.1 A deficit of £0.68m is reported against expenditure budgets in October, reflecting an over spend of £0.45m on pay and an over spend of £0.23m on non pay.

4.2 There was an adverse variance on Medical pay of £0.23m in month, which is an increase on the average trend of previous months. Nursing Pay overspent by £0.20m in month and Other Pay (AHPs and Admin staff) overspent by £0.02m.

4.3 A key impact on nursing pay this month has been the new PASA rates which came into force from 1st October. It has been estimated that there will be an adverse variance of £0.1m per month in relation to this.

4.4 The graph below shows the trend of nursing agency hours by Directorate over the period from October 2008 – October 2009.




The trend line shows that whilst agency hours have reduced significantly during the first and second quarters, further actions are required to reduce usage still further. The Trust is currently exploring options to encourage nurses to join the Trust either as permanent staff or on the staff bank.

4.5 The non-pay budget for the Trust is showing a negative variance of £0.23m in Month 7. The HIV tariff drugs position improved this month with an under spend against budget of £0.19m. However in terms of clinical supplies, there was a continued overspend in month on prosthetics, medical and surgical supplies and the Pathology contract with Imperial NHS Trust.

**Balance Sheet (Form F6)**

## 5 Working Capital Days

The key working capital performance indicators are set out in the table below:

| | Oct 09 | Mar 10 | |
|---|---|---|---|
| | Current Month Actual | Forecast | Monitor Plan |
| Stock days | 26 | 26 | 35 |
| NHS Trade Debtor days | 17 | 13 | 8 |
| Non-NHS Trade Debtor days | 4 | 5 | 21 |
| Trade Creditor days | 30 | 30 | 35 |
| Liquid Ratio (days) | 10 | 17 | 27 |
| Return on Assets Employed | 5.3% | 5.5% | 5.0% |

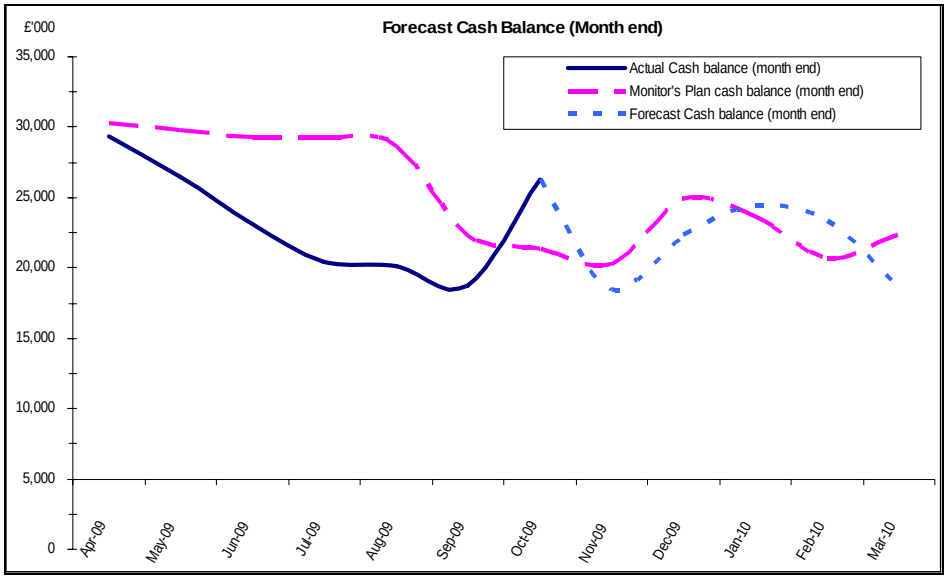
* This ratio is based on the Trust's methodology which excludes payroll and bank staff however it should be noted that Monitor calculate this ratio using total operating expenditure

## 6 Cash Position

6.1 The cash position at the close of the month was £26.3m compared with the Monitor plan of £21.4m which is higher than plan by £4.9m. However within this position is should be noted that the Trust received early payment of SLA of £8.3m. The table below shows the key variances from plan and any actions.

| Cash Flow | YTD Plan Variance(£m) (adverse)/ favourable | Explanation for variance and plan for recovery |
|---|---|---|
| Early payment of SLAs | 8.3 | Relates to month 8, mainly Kensington & Chelsea PCT. |
| Debtors (excl prepayment): Timing differences of PCT clinical and non-clinical activities income | -11.3 | Variance due to plan assuming 98% of activity income collected in month for significant over performance and non contracted activities that are billed quarterly. |
| Capex under spend | 6.8 | Delay in approval of 2009/10 capital programme has led to later starts to new projects than planned. |
| Non-cash flows in operating surplus | -1.8 | Non-cash flow in operating surplus is adverse against plan by £1.8m, of which £1.5m is the depreciation adjustment as a result of reflecting the residual value of buildings. |
| Other | 2.9 | |
| Total Cash Flow Variance | 4.9 | |

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




6.3 The year end forecast cash balance is £3.6m lower than Monitor plan:

- There is a £2.9m adverse variance in Net Cash Flows from Operating Activities.

- Within Investing Activities there is a £11.7m under spend against the Monitor plan as a result of re-phasing the capital programme.

- Within Financing Activities there is an adverse net impact of £12.4m on the cash flow forecast as a result of not drawing down the £13m loan due to the deferral of the Netherton Grove project

## 7 Capital Programme

7.1 The Capital Budget for the year advised to Monitor is £35.5m. The revised budget for the year at 31 October 2009 is £23.7m

7.2 The Board has approved an expansion of paediatric facilities, the Netherton Grove Build project, for £36.28m. The majority of the expenditure will take place in 2010/11 and 2011/12.

## 8 Forecast

8.1 The forecast for the year end is a net surplus of £6.62m, which is £0.22m above the planned surplus of £6.40m. The key risks within the position are:

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

- London-wide nurse agency contracts lapsed on 1st October. The Director of HR and Director of Procurement are seeking to renegotiate rates and are investigating ways of accelerating the current recruitment.

- The impact of a full blown swine flu pandemic has not been included in the forecast.

- Loss of income based on hospital infections impacting on bed occupancy and the length of time taken to achieve a full deep clean of the unit.

## 9 Recovery Plan Progress at M7

9.1 Each directorate has been tasked with drawing up a recovery plan with the aim of pulling back the forecast EBITDA shortfall by £2.7m. This will be monitored on a monthly basis.

**Lorraine Bewes**
**Director of Finance and Information**
**26th November 2009**

# Glossary of Terms

CIP: Cost Improvement Programme

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

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

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

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

Elective: Planned Care (non emergency)

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

NICU: Neonatal Intensive Care Unit

SCBU: Special Care Baby Unit

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

Tariff: Nationally agreed price for a particular procedure.

PASA: NHS Purchasing and Supply Agency

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

Acuity: Seriousness of a patient's condition

Locum: Temporary doctor covering vacancy or staff absence.

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

BPPC: Better Payment Practice Code

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

IM&T: Information Management and Technology

Monitor: Regulatory body for NHS Foundation Trusts.

# CHELSEA & WESTMINSTER HOSPITAL NHS FOUNDATION TRUST

## FINANCE REPORTS TO THE MEMBERS' COUNCIL

**October 09**

**CHELSEA & WESTMINSTER HOSPITAL NHS FOUNDATION TRUST**

# CONSOLIDATED INCOME & EXPENDITURE SUMMARY

**TRUST WIDE**

**FORM F1**
**October 09**

**Responsibility: Finance Director**

| | THIS MONTH | | | YEAR TO DATE | | | FULL YEAR | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | MONITOR | FULL YEAR | FORECAST | |
| | BUDGET | ACTUAL | VARIANCE | BUDGET | ACTUAL | VARIANCE | PLAN | BUDGET | ACTUAL | VARIANCE |
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **INCOME** | | | | | | | | | | |
| NHS Clinical Contract Income | (22,107) | (21,994) | (113) | (148,869) | (149,768) | 898 | (253,571) | (253,284) | (254,868) | 1,583 |
| Other NHS non tariff | (17) | (137) | 120 | (353) | (582) | 228 | | (677) | (875) | 198 |
| Other non-NHS Clinical revenue | (85) | (103) | 19 | (593) | (859) | 265 | (993) | (1,017) | (1,604) | 587 |
| Private Patient Income | (841) | (681) | (160) | (5,345) | (4,451) | (894) | (9,236) | (9,472) | (8,194) | (1,278) |
| Education & Training Income | (1,988) | (2,256) | 267 | (13,918) | (14,430) | 512 | (22,778) | (23,860) | (24,720) | 860 |
| Research & Development Income | (442) | (471) | 29 | (1,930) | (2,134) | 204 | (4,041) | (4,090) | (3,971) | (119) |
| Misc other operating income | (843) | (1,035) | 192 | (5,866) | (7,131) | 1,265 | (17,247) | (11,214) | (12,753) | 1,539 |
| **TOTAL INCOME** | **(26,323)** | **(26,676)** | **353** | **(176,876)** | **(179,354)** | **2,478** | **(307,866)** | **(303,614)** | **(306,985)** | **3,371** |
| **EXPENDITURE** | | | | | | | | | | |
| Medical Pay - Contracted | 4,060 | 3,957 | 102 | 28,506 | 27,564 | 943 | | 49,159 | 47,411 | 1,748 |
| Medical Pay - Locum | 12 | 346 | (334) | 84 | 2,005 | (1,921) | | 144 | 3,369 | (3,225) |
| Nursing Pay - Contracted | 5,102 | 3,991 | 1,111 | 35,542 | 27,272 | 8,271 | | 61,040 | 47,650 | 13,390 |
| Nursing Pay - Agency | 79 | 900 | (820) | 630 | 6,500 | (5,870) | | 695 | 9,696 | (9,002) |
| Nursing Pay - Bank | 48 | 536 | (489) | 121 | 3,805 | (3,684) | | 361 | 6,462 | (6,101) |
| Other Pay - Contracted | 3,773 | 3,191 | 582 | 25,867 | 21,809 | 4,057 | | 48,189 | 40,822 | 7,367 |
| Other Pay - Agency | 5 | 302 | (297) | 193 | 2,480 | (2,287) | | 208 | 3,477 | (3,269) |
| Other Pay - Bank | 6 | 315 | (308) | 48 | 2,271 | (2,223) | | 81 | 3,510 | (3,429) |
| **Sub-total Pay** | **13,086** | **13,539** | **(453)** | **90,992** | **93,706** | **(2,714)** | **160,026** | **159,876** | **162,398** | **(2,522)** |
| Clinical supplies | 2,599 | 2,936 | (337) | 18,094 | 19,326 | (1,233) | 32,126 | 30,770 | 32,467 | (1,697) |
| Non-clinical supplies | 3,230 | 3,419 | (189) | 22,259 | 22,231 | 28 | 40,289 | 37,240 | 39,554 | (2,314) |
| Drug Costs - Tariff | 3,290 | 3,175 | 115 | 21,993 | 23,215 | (1,222) | 46,967 | 37,077 | 38,034 | (956) |
| Drug Costs - Exclusions | 866 | 884 | (17) | 5,111 | 5,421 | (310) | | 8,649 | 9,608 | (960) |
| Education and training expense | 67 | 46 | 21 | 503 | 298 | 205 | 869 | 864 | 750 | 113 |
| Research & Development expense | 329 | 150 | 179 | 1,753 | 1,135 | 618 | 1,019 | 2,897 | 608 | 2,289 |
| **Sub-Total Non Pay** | **10,382** | **10,611** | **(229)** | **69,714** | **71,627** | **(1,913)** | **121,270** | **117,496** | **121,022** | **(3,526)** |
| **TOTAL COSTS** | **23,469** | **24,150** | **(681)** | **160,706** | **165,333** | **(4,627)** | **281,296** | **277,372** | **283,419** | **(6,048)** |
| **EBITDA** | **2,854** | **2,527** | **(328)** | **16,170** | **14,021** | **(2,149)** | **26,570** | **26,242** | **23,565** | **(2,677)** |
| ***EBITDA %*** | 10.8% | 9.5% | | 9.1% | 7.8% | | 8.6% | 8.6% | 7.6% | 118.0% |
| Depreciation | 848 | 611 | 237 | 5,704 | 4,217 | 1,487 | 10,277 | 10,022 | 7,532 | 2,490 |
| Interest Payable | 52 | 52 | 0 | 389 | 386 | 3 | 741 | 742 | 648 | 93 |
| Interest Receivable | (5) | (4) | (0) | (49) | (54) | 5 | 0 | (73) | (79) | 5 |
| PDC Dividend expense | 763 | 727 | 36 | 5,339 | 5,087 | 252 | 9,152 | 9,152 | 8,719 | 433 |
| Profit/Loss on Asset Disposal | 0 | 0 | 0 | 0 | 131 | (131) | 0 | 0 | 131 | (131) |
| **SURPLUS / (DEFICIT)** | **1,196** | **1,141** | **(55)** | **4,787** | **4,255** | **(532)** | **6,400** | **6,400** | **6,615** | **214** |

**Chelsea & Westminster Hospital NHS Foundation Trust**

# BALANCE SHEET

**Responsibility: Finance Director**

**FORM F6**
**October 09**

| | Mar 09 | Sep 09 | Oct 09 | Mar 10 | |
|---|---|---|---|---|---|
| | Opening Balance | Prior Month Actual | Current Month Actual | Forecast | Monitor Plan |
| | £'000 | £'000 | £'000 | £'000 | £'000 |
| **NON-CURRENT ASSETS** | | | | | |
| Property | 257,395 | 257,024 | 263,609 | 221,072 | 277,718 |
| Plant & Equipment | 26,589 | 26,282 | 26,024 | 30,121 | 30,295 |
| Assets under construction | 5,256 | 10,406 | 11,852 | 16,113 | 6,732 |
| | 289,240 | 293,712 | 301,485 | 267,306 | 314,746 |
| **CURRENT ASSETS** | | | | | |
| Inventories | 6,588 | 5,403 | 5,987 | 5,848 | 7,684 |
| NHS Trade Receivables | 6,565 | 16,927 | 12,698 | 9,737 | 5,971 |
| Non NHS Trade Receivables | 3,587 | 2,476 | 2,597 | 2,705 | 5,233 |
| Provision for Impairment of Receivables | (2,574) | (2,761) | (2,761) | (2,516) | (2,690) |
| Other Receivables | 3,069 | 3,520 | 2,490 | 2,650 | 2,510 |
| Accrued income | 312 | 953 | 406 | 632 | 559 |
| Prepayments | 458 | 1,676 | 1,803 | 1,217 | 761 |
| Cash and Cash Equivalents | 32,053 | 18,769 | 26,268 | 18,703 | 22,287 |
| | 50,058 | 46,963 | 49,488 | 38,977 | 42,313 |
| **CURRENT LIABILITIES** | | | | | |
| Borrowings | (1,470) | (1,470) | (1,470) | (1,470) | (2,402) |
| Finance Leases | (47) | (157) | (158) | (163) | (164) |
| NHS Trade Creditors | (7,798) | (6,242) | (5,876) | (6,217) | (7,922) |
| Non NHS Trade Creditors - revenue | (3,187) | (6,255) | (5,829) | (5,141) | (4,356) |
| Other creditors | (7,250) | (6,119) | (6,412) | (6,166) | (7,501) |
| Capital Creditors | (1,076) | (702) | (872) | (7,210) | (2,728) |
| PDC Dividend creditor | - | - | (727) | - | - |
| Interest Payable Creditor | - | - | (41) | - | - |
| Accruals | (10,036) | (8,602) | (9,709) | (9,630) | (8,130) |
| Deferred income | (5,660) | (2,264) | (2,938) | (1,793) | (280) |
| Provisions | - | (102) | (1,886) | (1,797) | (22) |
| | (36,524) | (31,913) | (35,918) | (39,589) | (33,503) |
| **Net Current Assets/(Liabilities)** | 13,534 | 15,051 | 13,570 | (612) | 8,810 |
| **Total Assets less Current Liabilities** | 302,774 | 308,763 | 315,055 | 266,694 | 323,555 |
| **NON-CURRENT LIABILITIES** | | | | | |
| Borrowings: FTFF - £12.5m facility | (9,560) | (8,825) | (8,825) | (8,090) | (8,090) |
| Borrowings: FTFF - £27m facility | - | - | - | - | (12,069) |
| Finance Leases | (2,145) | (2,475) | (2,449) | (2,463) | (2,463) |
| Deferred income | - | (3,400) | (3,400) | (3,400) | (3,822) |
| Provisions | (440) | (406) | (455) | (463) | (390) |
| | (12,145) | (15,107) | (15,129) | (14,416) | (26,834) |
| **Total Assets Employed** | 290,629 | 293,656 | 299,926 | 252,277 | 296,722 |
| **TAXPAYERS EQUITY** | | | | | |
| Public Dividend Capital | 162,549 | 162,549 | 162,549 | 162,549 | 162,549 |
| Revaluation Reserve | 91,320 | 91,320 | 91,320 | 42,912 | 91,320 |
| Donated Asset Reserve | 7,472 | 7,387 | 7,588 | 5,986 | 7,164 |
| Retained Earnings | 29,289 | 32,401 | 38,469 | 40,830 | 35,688 |
| **Total Taxpayers' Equity** | 290,629 | 293,656 | 299,926 | 252,277 | 296,722 |
| Committed Working Capital Facility | 20,000 | 20,000 | - | 20,000 | 20,000 |

**KPIs**

| | | | | | |
|---|---|---|---|---|---|
| Stock days | 33 | 24 | 26 | 26 | 35 |
| NHS Trade Debtor days | 7 | 23 | 17 | 13 | 8 |
| Non-NHS Trade Debtor days | 13 | 3 | 4 | 5 | 21 |
| Trade Creditor days | 31 | 33 | 30 | 30 | 35 |
| Liquid Ratio (days) | 53 | 38 | 10 | 17 | 27 |
| Return on Assets Employed | 6.4% | 5.0% | 5.3% | 5.5% | 5.0% |

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Council of Governors Meeting, 3 December 2009

| | |
|---|---|
| **AGENDA ITEM NO.** | 5.4/Dec/09 |
| **PAPER** | Performance Report for 7 months to 31 October 2009 |
| **AUTHOR** | Mohammad Wasim – Interim Information Manager |
| **LEAD** | Lorraine Bewes – Director of Finance and Information |
| **EXECUTIVE SUMMARY** | The purpose of this report is to update the Board on the Trust's service performance for the period ending 31st October 2009.<br><br>Performance against the Monitor selection of indicators is broadly on track, with the exception of the MRSA target where performance has deteriorated in October. We have had a total of 3 MRSA cases in October, which brings the year to date total to 8 cases. At this level we are unlikely to achieve the stretch A target (carrying a bonus of £100,000) of 10 cases for the year. We can however still achieve the stretch B target (£150,000) for Clostridium Difficile.<br><br>The Trust is currently at a 'fully met' rating for existing and national targets for the Care Quality Commission. (CQC)<br><br>There are some key risks that must be mitigated in order to achieve 'fully met' at the end of the year. These relate to the targets to have no inpatient waits above 26 weeks, no outpatient waits above 13 weeks, delivery of the 18 weeks target and concerns around MRSA as mentioned above.<br><br>The inpatient, outpatient and 18 week indicators can still be brought up to a fully met score to achieve a rating of 'Excellent' this year. However if current performance trend continues, this would equate to only a 'Good' performance. |
| **DECISION/ ACTION** | The Council is asked to note the report. |

## PERFORMANCE REPORT FOR THE PERIOD October 2009

### 1. PURPOSE

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

### 2. CONTENT OF PERFORMANCE REPORT

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

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

### 3. SUMMARY OF PERFORMANCE REPORT

**MONITOR**

In Quarter 2, the Trust met all Monitor targets that can currently be measured, although performance was only just within target for MRSA, as we had 4 breaches versus a target of 4.9.

3.1 Performance has deteriorated further at the start of Quarter 3. There were 3 cases of MRSA bacteraemia in October alone which brings the total for the 7 months YTD to 8. At this level, the Trust is still within its CQC target but now risks achievement of its stretch target (10) that would earn a £100k bonus. Of the 8 reported cases, 2 had community acquired bacteraemia and under current guidance may be offered in mitigation if the Trust exceeds its nationally set target of 19 cases.

3.2 In line with established practice, all cases when identified are immediately followed up by the Infection Control Team and, where necessary, immediate action taken. All cases are subject to a Root Cause Analysis (RCA) which is the responsibility of the Consultant in charge of the patient's care; all RCAs are reviewed by the Director of Infection Prevention and Control (DIPC).

3.3 From the RCAs, patients with invasive devices i.e. peripheral and central lines and who are colonised with MRSA are at increased risk of developing a MRSA bacteraemia. In 2 of the 8 cases reported blood cultures were taken inappropriately.

3.4 The MRSA screening target measures the number of elective admissions we have in a month and the number of MRSA swabs we do. If the ratio for swabs against admissions is greater than 1 then the target is met. The MRSA screening ratio was 1.38.

3.5 The number of C Diff cases was below the target in October. There have been 25 cases so far this year against a maximum target of 55 in that time. We are below the threshold of 27.5 for quarter three with only 1 case in the first month of quarter 3.

3.6 Monitor has confirmed that the target for the new 2 week wait for the urgent referral cancer standard is 93%. Our performance for the quarter was 98.64%

3.7 The Department of Health announced details of the operational standards for existing and new commitments to cancer waiting times. A decision was taken by DH to align the monitoring of cancer waiting times with the existing 18 weeks data collection methodology, with the consequence that the previous thresholds required to assess performance against 31- and 62-day commitments are no longer valid. See section 3.26 for further details.

Implications for Monitor's regulatory framework are as follows:

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

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

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

| **Targets – weighted 1.0 (national requirements)** | **Threshold** | **Weighting** | **October Performance** |
|---|---|---|---|
| 62-day wait for first treatment from urgent GP referral to treatment: all cancers | 85% | 1.0 | 100% |
| 62-day wait for first treatment from consultant screening service referral: all cancers | 90% | 1.0 | No referrals to date* |
| 31-day wait for second or subsequent treatment: surgery | 94% | 1.0 | 100% |
| 31-day wait for second or subsequent treatment: anti cancer drug treatments | 98% | 1.0 | 100% |
| **Targets – weighted 0.5** | | | |
| 31-day wait from diagnosis to first treatment: all cancers | 96% | 0.5 | 96.67% |
| Two week wait from referral to date first seen: all cancers | 93% | 0.5 | 98.64% |

**Table 1**: New Cancer targets

*we expect referrals to begin in January 2010, when the direct referrals service for screening begins.

3.9 Our A&E performance in October is 98.28% (98% target). See section 3.18 for further details

3.10 18 week Trust level performance was met in October with 99.07% in non-admitted and 93.18% in admitted. We have had no breaches at speciality level.

**Care Quality Commission**

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

***Existing commitments indicators***

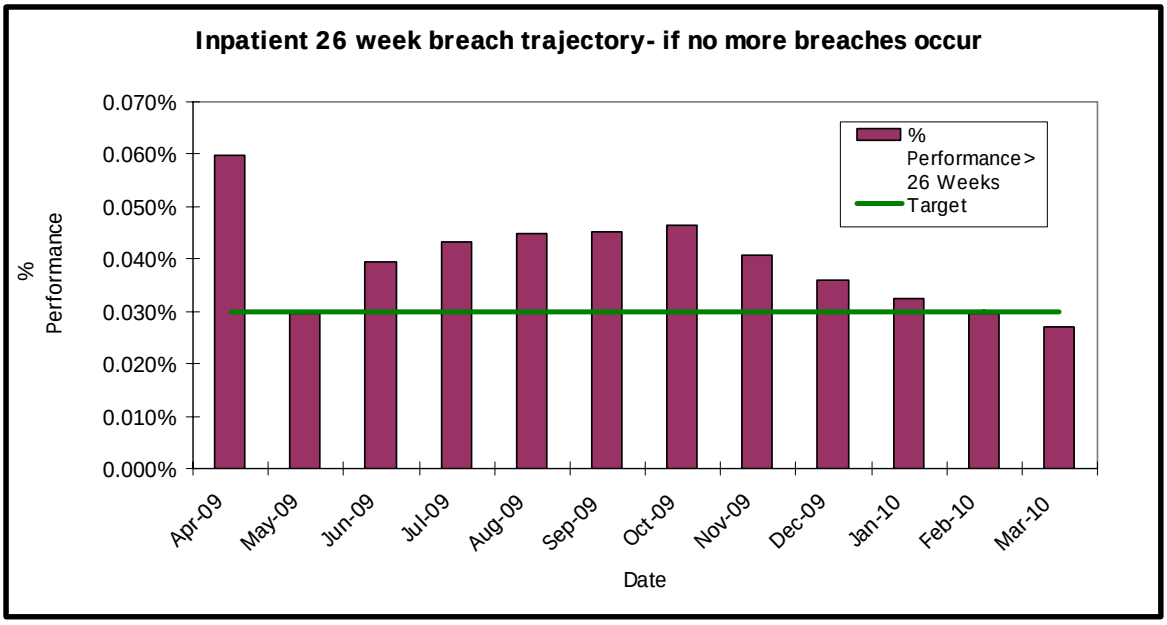
3.11 We are on track to receive 'Fully Met' rating for the Existing Commitment indicator group because despite the Inpatient 26 week indicator falling below the target (see Para 3.12), we have met all other targets to date. However, there are a number of risks which are outlined below.

3.12 The trust had 5 Inpatient breaches of the 26 week target in October. This brings our total breaches for the year to 6 and the performance to 0.046% against a target of 0.03%. The 6 breaches YTD relate to 3 patients; the first occurred in Pain management in April, the second was in General Surgery and counted four times and the last was in Ophthalmology.

3.13 The breach in April occurred in the Pain Management specialty. The patient was added to the waiting list in October 08 and was dated for May 09 (beyond 26 weeks), this was not discovered on the waiting list until after the month end and was therefore too late to rectify. The breach was not identified in the normal validation procedures as the patient had been validated from the 18 week position already, and was therefore thought to be in an appropriate position.

3.14 The 5 breaches discovered in October arose from the decision to admit form going missing between the outpatient clinic and the admissions booking office. The root causes of the April breach have been rectified and the October breaches were caused by completely different system problems.

3.15 Procedures for the delivery of correct forms between Outpatients and Admissions have been identified as requiring review and improvement. Newly developed information reporting will help to assure management that any patient given a decision to admit in outpatients is added to the admissions waiting list.



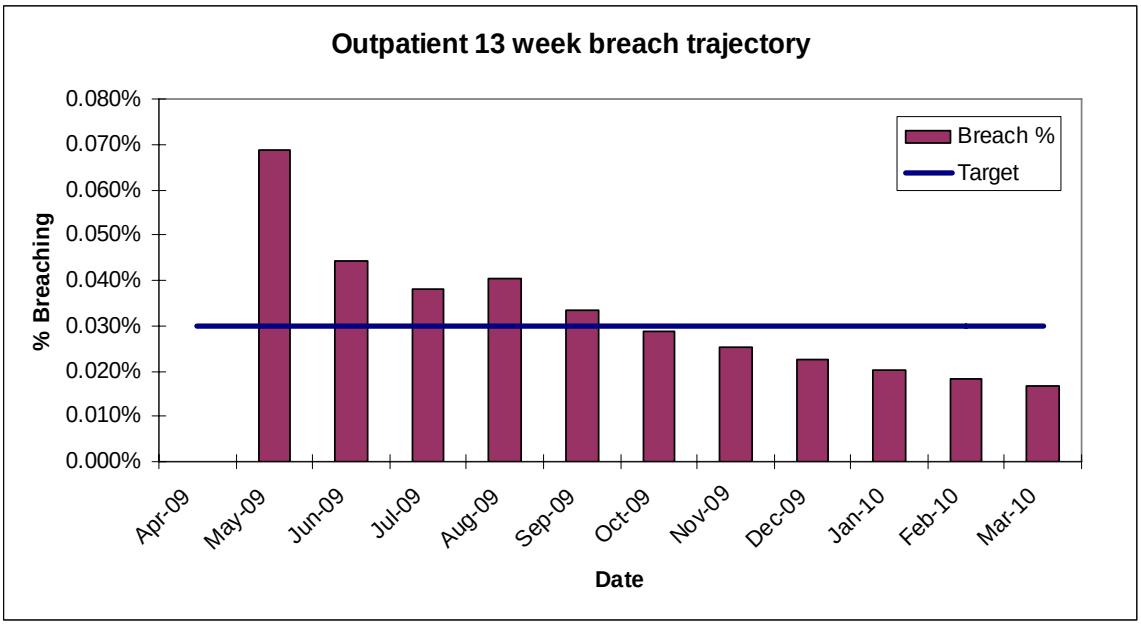

***Graph 1***. 26 week breach trajectory

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

3.17 The Trust's performance for data quality for ethnicity for October has improved to 96.3% against a target of 95%. We have had a 30% response to our patient mail shot and this has resolved the previous under performance reported.

3.18 We have had no further breaches of the 13 week standard in October. The total YTD breaches are 9. We are at 0.029% which is marginally below the threshold of 0.03%.

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




***Graph 2***. 13 week breach trajectory

3.20 We have had no further 28 day cancelled operation breaches in October and performance YTD is 97.18%.

3.21 The performance to date for cancelled operations by the hospital remains good for non-clinical reasons and is 0.41% (against a target of no more than 0.8%).

3.22 Our Performance for the Rapid Access Chest Pain Clinics in October was 100%, compared with an expected threshold of 98%.

| **RACPC REFERRALS** | | | |
|---|---|---|---|
| | **Total number of patients** | **% Complete** | **Patients seen within the target** |
| April | 39 | 100.00% | 39 |
| May | 28 | 100.00% | 28 |
| June | 25 | 100.00% | 25 |
| July | 25 | 100.00% | 25 |
| August | 17 | 100.00% | 17 |
| September | 19 | 100.00% | 19 |
| October | 43 | 100.00% | 43 |
| Total | 196 | 100.00% | 196 |

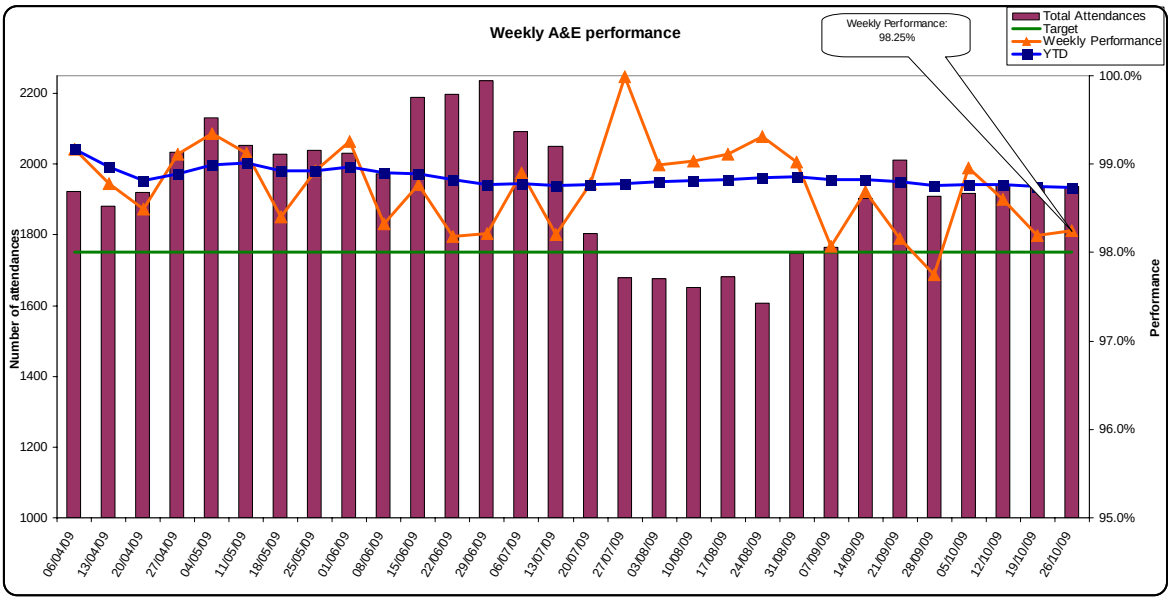
***Table 2****. RAPC analysis*

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

3.24 The Trust's performance against the delayed transfer of care target continues to be good. In October the cumulative performance was 0.93% against an expected threshold of 3.5%. The number of delayed transfer

patients has dropped significantly over the last calendar year from an average of five a week to an average of two.

3.25 Our performance for waiting times in A&E below a 4 hours wait is 98.65% for April to October. The number of A&E attendances has risen again but not to previous 'Swine flu' peak levels in July. This has adversely affected performance in October which has fallen to 98.29%. A&E activity and 4 hour wait performance since the start of the year is illustrated in Graph 3 below. Performance dropped at the end of September mainly due to the increase seen in patients at that time and staff sickness.




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

### *New National Priority indicators*

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

3.27 Our performance to date on data completeness for breastfeeding initiation to date is 99.96% (against a target of 95%) and data completeness for smoking during pregnancy to date is 99.22% (against a target of 95%). Failure to meet data completeness would mean the two standards below would not be assessed.

3.28 We have 0.93% less mothers smoking than last year and the target is to have less than last year. Last year, we had 4.81%, this year (YTD) we have 3.88%.

3.29 2.35% more mothers are known to initiate breastfeeding at delivery than last year. Performance is not allowed to worsen against last year by more than 5%.

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

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

The clarification of the way the target will be assessed will make it much simpler to gauge this indicator and we will do that for next month's report.

3.31 Access to healthcare for people with a learning disability is a new target. The Trust's position is not yet confirmed. A gap analysis has been undertaken and we are scored as partially met for all six indicators. A steering group has been convened to review the action plan. There are 2 actions for November which are linked to the identification of people with learning disabilities and ensuring there are protocols in place that ensure that pathways of care are reasonably adjusted to meet the health need of patients. An update will be available next month.

3.32 The Stroke indicator has been simplified; there are now only two parts to the indicator. The first looks at the percentage of stroke patients who are treated in the stroke unit. The trust performance year to date for this indicator is 99.94% against a target of 70% as set in the Vital Sign's framework for PCTs. The second is the percentage of Transient ischaemic attack (TIA) cases with a higher risk of stroke who are treated within 24 hours The trust's year to date performance is 81.3% against an expected target of 45%. There were no cases that could be included in October. These targets are set by the Department of Health and are expected to rise each year to push up performance throughout the NHS.

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

| **Indicator Name** | **YTD Performance** | **Performance Last Month** | **Target** |
|---|---|---|---|
| 31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers | **99.19%** | **96.67%** | **96.0%** |
| 31-Day Wait For Second Or Subsequent Treatment: Surgery | **97.26%** | **100.00%** | **94.0%** |
| 31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments | **100.00%** | **100.00%** | **98.0%** |
| 31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments | **N/A** | **N/A** | **94.0%** |

| | | | |
|---|---|---|---|
| 62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers | **97.53%** | **100.00%** | **85.0%** |
| 62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers | **N/A** | **N/A** | **90.0%** |
| All Cancer Two Week Wait | **97.57%** | **98.64%** | **93.0%** |

***Table 3*** CQC *Cancer targets summary*

## 4. 18 WEEK ACTIVITY

### 4.1. 18 week performance for Quarter 1

| | **Apr** | **May** | **June** | **Q1 Total** | **Q1 Target** | |
|---|---|---|---|---|---|---|
| **Admitted performance** | **90.98%** | **93.9%** | **95.00%** | **94.09%** | **90%** | **Achieved** |
| **Non-Admitted performance** | **99.20%** | **99.92%** | **98.82%** | **99.03%** | **95%** | **Achieved** |
| **Admitted speciality breaches** | **4** | **0** | **0** | **5 (in month)** | **4 across quarter** | |
| **Non-Admitted speciality breaches** | **1** | **0** | **0** | **2 (across quarter)** | | **Achieved** |

### 4.2. 18 week performance for Quarter 2

| | **July** | **August** | **September** | **Q2 Total** | **Q2 Target** | |
|---|---|---|---|---|---|---|
| **Admitted performance** | **95.59%** | **94.03%** | **92.46%** | **94.02%** | **90%** | **Achieved** |
| **Non-Admitted performance** | **99.20%** | **98.68%** | **98.98%** | **98.95%** | **95%** | **Achieved** |
| **Admitted speciality breaches** | **0** | **0** | **0** | **1 (in month)** | | |
| **Non-Admitted speciality breaches** | **0** | **1** | **0** | **1 (across quarter)** | **2 across quarter** | **Achieved** |

### 4.3. 18 week performance for October 2009

| | **Treated within 18 weeks** | | **Not treated within 18 weeks** | | **Total volume** | **Unknown clock start date Volume** | **Data Completeness** (Threshold 90-110%) |
|---|---|---|---|---|---|---|---|
| | % | Volume | % | Volume | | | |
| Admitted | **93.18** | 1065 | 6.82 | 76 | 1143 | 2 | **91.35** |
| Non-admitted | **99.07** | 11594 | 0.93 | 109 | 11703 | 1 | **95.65** |

### 4.4. Predicted 18 week performance for November 2009

| | **Treated within 18 weeks** | **Not treated within 18 weeks** | **Total volume** | **Unknown clock start** |
|---|---|---|---|---|

| | % | Volume | % | Volume | | **date Volume** |
|---|---|---|---|---|---|---|
| Admitted | **91.91** | 1147 | 8.19 | 101 | 1248 | |

4.5 Performance for the year is currently on target; however, the position for Quarter 1 has now been clarified and the correct position is as reported in table 4.1 above. This means that there were 2 breaches across the quarter (vs a target of 4) rather than none as was previously reported.

4.5. Performance in October was positive with both bottom line targets being met. Admitted was 93.18% and non-admitted was 99.07%. There were no specialty breaches during the month.

4.6. November's forecast for admitted patients projects us meeting the bottom line targets but Plastic Surgery is currently 5 patients short of meeting the target in month. This leaves little margin for the quarter with the overall position being above the target across the three months.

4.7. The backlog has been validated such that we are in a position to enable us to bring forward potential breaches in paediatric dentistry and paediatric surgery from January into December without compromising the target. Previous data indicated this was the pressure point for quarter four, which is now mitigated.

4.8. DH is changing the basis of reporting 18 week performance from monthly aggregate returns to weekly patient level returns through SUS from January (first report submission due 23rd February). Currently the trust's 18 week return is based on an algorithm PTL as a software upgrade was required to report on a pathway-led PTL. Each month the algorithm PTL is reviewed and significant validation is completed each month. However the validations are not currently updated on Lastword, due to capacity, and therefore the SUS returns would not show a true picture of our 18 week performance. The Trust now has a patient led pathway functionality, but extensive training is required to embed its usage. A training programme is under way and a contingency for reporting is being developed in case this training is not completely rolled out in time for the January return.

## 5. DISCHARGE SUMMARY TARGET

5.1. The October 2009 Monthly Discharge Summary target performance dipped to 84% from 86% the previous month.

5.2. Performance on discharge summary completion within 48 hours for the month of October was 79.79% for inpatients and 88.48% for daycases.

5.3. From October 2010 the target is 100% discharge summaries being completed and sent within 24 hours. We are currently at 80% within 24 hours.

## 6. CHOOSE AND BOOK

6.1. Slot availability is measured by the proportion of bookings where there were no slot issues and the appointment was made successfully. In

2008/09 the target was 80%. Average performance for the year to date is 70.61% and October was 68.58%. This is being investigated as part of demand and capacity analysis led by the Director of Operations.

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

## 7. EFFICIENCY (AND OTHER TARGETS)

7.1. At the end of October 99.72% of clinical coding was being completed within the 7 day target. The internal target for the year is 98%.

7.2. Efficiency and Use of Resources –

- The Trust's daycase rate is 75.2% in October 2009. The target for the year is 73%. Benchmark data shows that for October to December 2008 the national average was 73.34% with the top 25% of Trusts scoring over 79.45%.
- Elective average length of stay year to date is behind plan at 3.14 (against a target of 3.00) but non-elective average length of stay year to date is ahead of plan at 3.15 (against a target of 4.00).
- The percentage of outcomes recorded in outpatients is at 92.7% compared with 94.5% for the previous year.
- The outpatients delivery group's agenda has been given over to this issue, which is a well attended event by clinical staff.

## 8 HUMAN RESOURCES PERFORMANCE

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

| **HR Metric** | **Target** | **2008/2009** | **Year to Date** |
|---|---|---|---|
| Turnover rates | 14% | 16.71% | **14.36%** (rolling 12mths : Nov 08 - Oct 09) |
| Stability rates | 97% | 95.9% (excluding Jnr Drs) | **96.44%** (excl Jnr Drs : rolling 12mths : Nov 08 – Oct 09) |
| Vacancies: | | | |
| total | 10% | 12.28% | **15.46% avg** |
| active | 4% | n/a | **4.67% avg** |

| | | | |
|---|---|---|---|
| Sickness absence rates | 3.75% | 3.70% | **3.02% avg**<br>(April 09 – Sept 09) |

8.2 In October, the Trust staff in post increased by 47.85 wte in comparison to the previous month. This is the largest number of staff the Trust has ever employed for the twelfth consecutive month and represents a total increase in the overall workforce of 165.80 wte on the October 2008 position. Unplanned turnover (i.e. resignations) decreased in October, now at 1.04%. This is 0.17% lower than the same period last year. Turnover for the twelve month period ending October 2009 was 14.36%

8.3 The Trust's vacancy rates are calculated using the budgeted wte (based on reconciliations with the Finance department), and the wte staff inpost at the end of the month. This represents the 'total vacancy' position. The full Trust vacancy rate for October 2009 showed a decrease on the previous month, down to 14.89%. This represents a 2.6% increase on the same period in the previous year. The year to date figure is 15.46%.

Substantial recruitment of qualified nurses has taken place in Maternity and Paediatrics throughout October, with 19 new nurses starting in these areas. A truer measure of vacancies is those being actively recruited to, based on unique jobs being advertised through NHS jobs throughout October. Our year to date average active vacancy rate is 4.67%

8.4 The Trust's sickness rate showed a 0.64% increase in September, up to 3.15%, however this is down 0.81% on the same period last year. This brings the YTD sickness rate to 3.02%.

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

More detailed sickness information by employee in the form of sickness trigger reports are sent via the HR Administrators to department/ward managers on a monthly basis to progress absence management.

The HR team review every case of long term absence or high levels of intermittent short term absence, and support managers with their action plans to address each individual case.

8.5 The Trust has seen a small increase in Bank and Agency usage for October 2009, with total usage up 29.63 wte on last month.

| | **August 2009** | **September 2009** | **October 2009** |
|---|---|---|---|
| **Vacancy** | 473.08 wte | 457.02 wte | 474.43 wte |
| **B&A usage** | 401.88 wte | 397.34 wte | 426.97 wte |
| **Vacancies – B&A usage** | **71.09 wte** | **65.91 wte** | **47.46 wte** |

## 9 SLA PERFORMANCE AND ACTIVITY

9.1 The performance against planned contract income by point of delivery is shown in the following table and shows that activity (before prior year) at

944,766 is only 0.6% ahead of plan. Planned activity continues to under-perform which is being mitigated by high emergency and Burns Critical Care activity.

| Activity Type | Currency | Activity Actual | Activity variance % | Surplus / (Deficit) October 2009 |
|---|---|---|---|---|
| Elective | Spells/FCE's | 3,299 | -1.1% | 39.7 |
| Planned Same day | Spells/FCE's | 12,495 | -3.8% | - 371.4 |
| Regular days | Spells/FCE's | 4,364 | -14.5% | - 13.0 |
| Non Elective | Spells/FCE's | 20,238 | 10.2% | 461.1 |
| Critical Care – Adult | Bed days | 1,621 | 0.2% | 62.7 |
| Critical Care – Burns | Bed days | 358 | 473.4% | 668.6 |
| Critical Care - NICU/SCBU | Cot days | 6,576 | -3.9% | - 397.5 |
| A&E attendances | Attendances | 59,225 | 0.4% | 20.0 |
| Outpatients(incls procedures and virtual clinics) | Attendances | 251,876 | 0.8% | 48.6 |
| Excess Bed Days | Excess bed days | 11,088 | 33.9% | 874.8 |
| Other | Tests and Provisions, Critical care correction | 573,625 | 0.0% | - 1,320.9 |
| **Total for 2009/10** | | **944,766** | **0.6%** | **72.8** |
| Prior Year | | 3,491 | | 885.8 |
| **Grand Total** | | **948,257** | **0.6%** | **958.6** |

* RDA = Regular Day Attenders
* PSD = Procedures same day

9.2 Elective activity is currently showing an activity deficit of (1.1) % which equates to 35 spells this represents a significant improvement in month from (4.9%). Planned same day procedures are behind plan by 3.8% or 484 spells, unlike elective there has been no in month improvement. The table below breaks down the major variances by Directorate and Speciality

**Table: Elective inpatient variance by Directorate and Speciality**

| POD | Speciality | Directorate | Activity Plan | Activity Actual | Activity Difference | % variance |
|---|---|---|---|---|---|---|
| Elective | Plastic Surgery | Surgery | 360.39 | 275.00 | -85.39 | -23.7% |
| | HIV | HIV | 97.87 | 45.00 | -52.87 | -54.0% |
| | Trauma & Orthopaedics | Surgery | 542.77 | 493.00 | -49.77 | -9.2% |
| | Obstetrics | W & C | 56.90 | 20.00 | -36.90 | -64.9% |
| | Paediatric Surgery | W & C | 185.09 | 150.00 | -35.09 | -19.0% |
| | Gynaecology | W & C | 466.50 | 442.00 | -24.50 | -5.3% |
| | Urology | Surgery | 324.29 | 310.00 | -14.29 | -4.4% |
| | Medical Oncology | Medicine | 31.83 | 22.00 | -9.83 | -30.9% |
| | All other | All | 454.47 | 421.00 | -33.47 | -7.4% |
| | Dermatology | Medicine | 12.73 | 23.00 | 10.27 | 80.6% |
| | Neurology | Medicine | 17.60 | 29.00 | 11.40 | 64.8% |
| | Paediatric Orthopaedics | W & C | 51.76 | 69.00 | 17.24 | 33.3% |
| | Burns care | Surgery | 28.56 | 47.00 | 18.44 | 64.6% |
| | Paediatric ENT | W & C | 128.71 | 149.00 | 20.29 | 15.8% |
| | Well Babies | W & C | 0.87 | 37.00 | 36.13 | 4134.2% |
| | General Medicine | Medicine | 47.32 | 89.00 | 41.68 | 88.1% |
| | General Surgery | Surgery | 526.75 | 678.00 | 151.25 | 28.7% |
| | **Sub total Elective** | | **3,334.40** | **3,299.00** | **-35.40** | **-1.1%** |
| Planned same Day | Medical Oncology | Medicine | 313.89 | 139.00 | -174.89 | -55.7% |
| | Respiratory Medicine | Medicine | 243.26 | 139.00 | -104.26 | -42.9% |
| | Neurology | Medicine | 190.57 | 88.00 | -102.57 | -53.8% |
| | HIV | HIV | 358.38 | 260.00 | -98.38 | -27.5% |
| | Ophthalmology | Surgery | 697.91 | 606.00 | -91.91 | -13.2% |
| | Trauma & Orthopaedics | Surgery | 514.56 | 431.00 | -83.56 | -16.2% |
| | Plastic Surgery | Surgery | 967.62 | 886.00 | -81.62 | -8.4% |
| | Urology | Surgery | 1,035.11 | 973.00 | -62.11 | -6.0% |
| | Nephrology | Medicine | 118.01 | 71.00 | -47.01 | -39.8% |
| | Gastroenterology | Medicine | 3,012.92 | 2,975.00 | -37.92 | -1.3% |
| | Haematology (Clinical) | Medicine | 434.85 | 398.00 | -36.85 | -8.5% |
| | Elderly & Gen Medicine | Medicine | 289.62 | 230.00 | -59.62 | -85.8% |
| | Cardiology | Medicine | 84.12 | 57.00 | -27.12 | -32.2% |
| | Paediatric Surgery | W & C | 1,768 | 1,863 | 95 | 0 |
| | Accident & Emergency | Medicine | 19.85 | 4.00 | -15.85 | -79.9% |
| | All Other | All | 129.45 | 175.00 | 45.55 | 35.2% |
| | Gynaecology | W & C | 1,033.81 | 1,046.00 | 12.19 | 1.2% |
| | Rheumatology | Medicine | 313.85 | 332.00 | 18.15 | 5.8% |
| | Endocrinology | Medicine | 71.37 | 92.00 | 20.63 | 28.9% |
| | Pain Management | A & I | 384.19 | 441.00 | 56.81 | 14.8% |
| | General Surgery | Surgery | 527.56 | 593.00 | 65.44 | 12.4% |
| | Burns care | Surgery | 38.32 | 113.00 | 74.68 | 194.9% |
| | Paediatrics | W & C | 442 | 583 | 141 | 32% |
| | **Total Planned Same day** | | **12,989.25** | **12,495.00** | **-494.25** | **-3.81%** |

9.3 Non-elective with a positive variance of £0.461m is 10.2% above plan, however, this represents a slight adverse in month movement of £ (0.11) m.

9.4 General Medicine continues to be the main contributor with an 17.8% increase over the cumulative plan to month 6 but at month 5 the activity variance 18.2% therefore activity has fallen significantly in month, however the General Medicine over-performance is still off-setting the significant under-performance in Elderly Medicine (down by 32% on plan) and the two specialties need to be looked at together because of how the HRG 'Grouper' works. Obstetrics continues to show a significant over-performance. The table below breaks down the major activity variances by Directorate and Speciality.

**Table: Non Elective inpatient variance by Directorate and Speciality**

| POD | Speciality | Directorate | Activity Plan | Activity Actual | Activity Difference | % variance |
|---|---|---|---|---|---|---|
| Non Elective | Elderly medicine acute | Medicine | 848.03 | 581.00 | -267.03 | -31% |
| | Paediatric Surgery | W & C | 356.38 | 262.00 | -94.38 | -26% |
| | Respiratory Medicine | Medicine | 133.58 | 56.00 | -77.58 | -58% |
| | Trauma & Orthopaedics | Surgery | 684.42 | 612.00 | -72.42 | -11% |
| | Dermatology | Medicine | 78.96 | 48.00 | -30.96 | -39% |
| | Urology | Surgery | 164.94 | 134.00 | -30.94 | -19% |
| | Paediatric Gastroenterology | W & C | 102.09 | 73.00 | -29.09 | -28% |
| | Haematology (Clinical) | Medicine | 49.17 | 22.00 | -27.17 | -55% |
| | Paediatric Community | W & C | 31.52 | 11.00 | -20.52 | -65% |
| | Paediatrics | W & C | 1,213.05 | 1,195.00 | -18.05 | -1% |
| | Plastic Surgery | Surgery | 1,245.74 | 1,230.00 | -15.74 | -1% |
| | Neonatal Surgery | W & C | 54.28 | 41.00 | -13.28 | -24% |
| | All Other | All | 1,748.96 | 1,772.00 | 23.04 | 1% |
| | Anaesthetics | A & I | 30.64 | 54.00 | 23.36 | 76% |
| | Paediatric Plastic Surgery | W & C | 63.03 | 95.00 | 31.97 | 51% |
| | Cardiology | Medicine | 23.40 | 91.00 | 67.60 | 289% |
| | General Surgery | Surgery | 985.68 | 1,062.00 | 76.32 | 8% |
| | Gastroenterology | Medicine | 131.66 | 249.00 | 117.34 | 89% |
| | A & E Observation | Medicine | 1,354.31 | 1,669.00 | 314.69 | 23% |
| | General Medicine | Medicine | 2,574.78 | 3,001.00 | 426.22 | 17% |
| | Obstetrics | W & C | 6,487.22 | 7,980.00 | 1,492.78 | 23% |
| | Grand Total | | 18,361.84 | 20,238.00 | 1,876.16 | 10% |

9.5 Critical Care bed days for the Burns Unit show a 470% increase over plan. This is due to the plan being set on Intensive Care (ICU) activity only using month 6 2008/09 data to extrapolate the activity to inform the plan for 2009/10, as previously. Further work is being carried out with the Specialist Commissioners to agree how to manage the significant pressure that they face, one option they are looking at is a revision to the critical care bed day tariff which could result in a risk to the level of income received. A provision of £0.3m has been made to mitigate any potential funding reduction from the Specialist Commissioners.

9.6 The NICU/SCBU cot days are behind plan by 264 cot days which represents an adverse in month movement of 170 cot days. Reduction in capacity is a consequence of building works required to support the opening of the planned additional 11 cots.

9.7 Adult ITU/HDU occupancy increased in October, but Burns activity fell considerably with only 10 occupied bed days in October. It is likely that Critical Care bed days in November will be lost due to the asynobacter infection and time required to clear the unit to enable a deep clean. Currently Burns ITU beds are being flexed to take General Adult ITU.

**The table below shows the number of beds and cots that are available in critical care and the occupancy rates for October 2009 against the planned occupancy.**

**Critical Care Bed/Cot days**

| Critical Care – Neonatal | Rate per cot day | No of cots | Cot days | Occupancy | Planned Occupancy |
|---|---|---|---|---|---|
| ITU | 1,175 | 10 | 1,517 | 71% | 80% |
| HDU | 914 | 8 | 2,227 | 130% | 80% |
| SCBU | 350 | 14 | 2,832 | 94% | 80% |
| **Total** | | **32** | **6,576** | **96%** | **80%** |

| Critical Care - Adult | Rate per bed days | No of Beds | Bed days | Occupancy | Planned Occupancy |
|---|---|---|---|---|---|
| ITU | £1,802 | 6 | 881 | 679 | 80% |
| HDU | £1,190 | 4 | 740 | 83% | 80% |
| **Total** | | **10** | **1,621** | **76%** | **80%** |

| Critical Care - Burns | Rate per bed days | No of Beds | Bed days | Occupancy | Planned Occupancy |
|---|---|---|---|---|---|
| ITU | £3,464 | 2 | 308 | 72% | 80% |
| HDU | £1,764 | | 50 | 11% | |
| **Total** | | **2** | **358** | **83%** | **80%** |

**Please note cots/beds are flexed depending upon need**

9.8 Cumulative A&E attendances of 59,225 as at month 7 is still above plan and rose significantly in month.

9.9 The impact of the budget being re-phased has significantly reduced the outpatient adverse variance but GUM and the surgical specialities performance against plan remains an issue.

- GUM attendances and outpatient procedures are 2.1% below plan to the end of month 7. The Service is still only partially meeting the activity growth expectation for Dean Street as although Dean Street activity is now at plan, there have been reductions in the other clinics but in month improvement as month 6 variance was 4.4%

- All the surgical specialties continued to under-perform against the plan. Plans to recover ophthalmology and urology have been completed but T&O recovery plans still need to be completed.

9.10 Excess Bed days continue to over-perform in month 7 assisted by continued high levels of activity being coded and a change in guidance which allows specialist top up to be added the excess bed day charge.

## 10 CONCLUSION

10.1 The Trust met all in month Monitor targets and is on track to achieve 'fully met' in Existing and National CQC targets. However, there are some key risks in relation to delivering the inpatients 26 weeks target and the outpatients 13 week breach threshold (0.03%). We are able to have up to 5 further outpatient breaches in the year and cannot afford any further inpatient breaches and this will be dependent upon activity levels remaining in line with trend throughout the remainder of the year.

10.2 Finally, as reported under Section 4, there are risks to delivery of the 18 weeks target, both in terms of capacity in paediatric dentistry, paediatric surgery and plastic surgery and due to the change in reporting to a more granular patient level through SUS from January. The Trust has carried out a risk assessment and believes that mitigations are in place to address this.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Council of Governors Meeting, 3 December 2009

| | |
|---|---|
| **AGENDA ITEM NO.** | 5.5/Dec/09 |
| **PAPER** | Chief Executive's Report on the Strategy Workshop |
| **AUTHOR** | Heather Lawrence, Chief Executive |
| **LEAD** | Heather Lawrence, Chief Executive |
| **EXECUTIVE SUMMARY** | This report outlines key issues brought to the attention of the Council of Governors and feedback received. |
| **DECISION/ ACTION** | The Council is asked to note the report. |

**Council of Governors Strategy workshop**

On Friday 11th September Amit Khutti and I led a session on Strategy with 11 representatives from the Council of Governors, Charlie Wilson and the Chairman. We commenced with a presentation to the group on the 'Healthcare for London' Lord Darzi report and explained how this is planned to be implemented in NW London. A copy of the presentation is enclosed.

We separated out into two groups to encourage wider debate and asked each group to consider four key questions (set out below) and asked each group to feedback their views to the main group.

***Question 1: Do you agree that Chelsea and Westminster Hospital Foundation Trust should aim to be a specialist and local hospital?***

**Answer:**
Yes.

- Chelsea and Westminster Hospital Foundation Trust is widely recognised as the local hospital for local residents.

- The group recognised the need to promote the hospital as a specialist hospital for a range of services e.g.

    - HIV
    - Specialist Paediatrics
    - High risk maternity
    - Burns
    - Bariatrics

***Question 2: Do you support Chelsea and Westminster Hospital Foundation Trust in developing out of hospital care?***

***a) In Polysystems/Polyclinics?***
***b) By providing more community services***
***c) By providing mobile services for hard to reach groups***

**Answer:**

a) Yes. The group supported the Trust providing services in Polysystems/Polyclinics

b) Partially. There was a view that by pursuing generic community services we would not be focusing on core business and therefore we should only consider this in relation to specific services / care pathways e.g. children.

c) This was discussed as part of, Sian Nelsons presentation, see question 4.

***Question 3: If Chelsea and Westminster Hospital Foundation Trust needs to grow, what is your response to us acquiring a local hospital?***

**Answer:**
The group would wish to consider this further and to understand the benefits particularly in relation to service synergies.

***Question 4: Do you support Chelsea and Westminster Hospital Foundation Trust developing Specialist Services to a much wider community?***

**Answer:**
The group asked if this was about our staff delivering the service or whether it was about process and knowledge. Dean Street was cited as an example where we provide services to a wider catchment area. We also discussed our proposed partnership with Clinicenta to provide clinical governance support to their services in sites across London. The group was positive about expanding our Specialist Services.

The session was helpful in getting the Council of Governors representatives to understand the environment in which we are working. Sian Nelson, Membership and Engagement Manager/MPALS also made a presentation on a proposal she had developed with two of the Trusts Consultants to develop an Outreach Service for Men's Health. The proposal that will require a business case is for a mobile clinic to be setup at Chelsea Football ground. Sian Nelson has gained approval to site the mobile clinic at the Chelsea Football ground and has some commissioning support for the proposal. If she is successful a key aim is also to attract membership to the FT from a wider audience, young men, not currently sufficiently represented in our membership.

# Chelsea and Westminster Hospital NHS Foundation Trust

Members Council Strategy Day

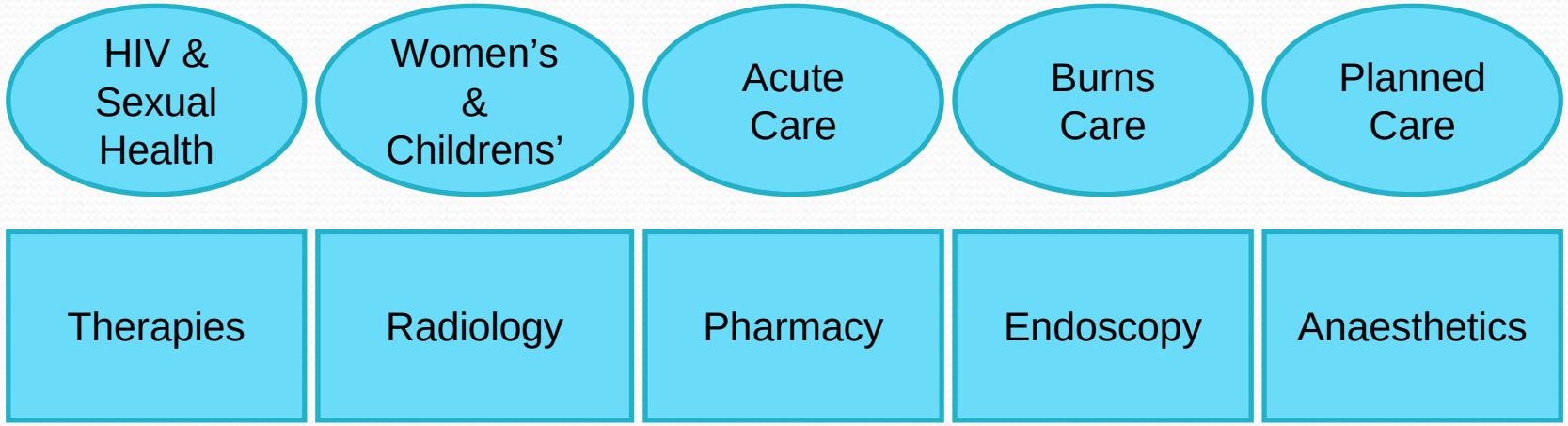
11th September 2009

# Purpose of today's meeting

- To share with the Members' Council what is going on in the NHS environment and what this means for North West London and for C&W
- To share the options available to us as a Trust
- To get feedback from the Members' Council as part of the Board refresh of our Trust strategy

# Who are we and what do we do?

- Vision: *"To deliver safe care of the highest quality for our local population and those using our 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."*



# We have enjoyed considerable success as a Trust

**Successes**

- Hospital Standardised Mortality Rate amongst best in country
- Low infection rates
- Excellent patient feedback
- Delivered national targets and strong financial performance
- Care Quality Commission rating for 2007/08 was ‘Good’ for quality of services and ‘Excellent’ for finance

**What has helped us to succeed?**

- Strong reputation
- Strength of supporting services especially pharmacy and anaesthetics
- Emphasis on safety
- Robust performance management with a culture of achieving targets – both financial and non-financial
- Benefits of modern physical infrastructure
- Some underlying financial benefits

# However, we cannot stay as we are in future

NHS London vision is for centralisation of specialist care and for routine care to be delivered outside of hospitals

Public sector spending cuts will accelerate NHS London plans

Work by North West London PCTs likely to involve changes to hospitals

NHS London vision is for centralisation of specialist care and for routine care to be delivered outside of hospitals

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# The vision for the NHS in London is about implementing *Healthcare for London (HfL)*

Five principles of future healthcare in *Healthcare for London* report (2007)

1. Services focussed on individual needs and choices
2. Localise where possible, centralise where necessary
3. Integrated care and partnership working, maximising the contribution of the entire workforce
4. Prevention is better than cure
5. A focus on health inequalities and diversity

# *HfL* recommended six types of settings in which health care should be delivered

**Home**

**Polyclinic**

**Local Hospital**

**Elective Centre**

**Major Acute Hospital**

(Including 3 AHSCs in London)

**Specialist Hospital**

NHS London vision is for centralisation of specialist care and for routine care to be delivered outside of hospitals

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# Centralisation of specialised care underway

| Areas of work where centralisation is agreed |
| --- |
| • Major trauma |
| • Stroke |
| • Specialised children's services – surgery in North West London |

| Areas being reviewed where centralisation likely |
| --- |
| • Specialist cancer |
| • Cardiac services |
| • Specialised children's services – London wide |

# Several of the actions proposed to reduce the gap will impact on hospitals

| | | Description |
|---|---|---|
| 1 | Shift to lower cost setting | • Move low complexity, routine work out of hospitals and closer to home, reducing the price |
| 2 | LTC and case management | • Provide care proactively for people outside of hospital to prevent use of hospital services |
| | Prevention | • Reduce demand by addressing health behaviours to prevent ill-health and by improving screening for ill-health |
| | De-commissioning | • Stop commissioning low value added activity, e.g. varicose veins, unnecessary follow-ups |
| 3 | Reduced unit costs in non acute sector | • Reduce unit price of non-acute services to be delivered within a polysystem setting |

# Commissioners have prioritised areas of *HfL* in response to these financial pressures

- Transformation of primary and community care
  - Focus on ‘polysystems’ with personalised approach to prevention, treating chronic conditions and urgent care centres;
  - Management of 50% outpatients, minor ops and 60% current A&E activity;
- Transformation of acute care
  - Localise low-complexity activity into polysystems, centralise specialised services in major acute hospitals
  - Increased choice in maternity
  - Overall reduction in hospital spend

# Polysystems – a case study

| Long-term conditions – Kishore is 45 and overweight with type II diabetes | |
|---|---|
| **Current** | **Future** |
| • Diagnosed with diabetes two years ago; went to see GP after wife nagging him for three years;<br>• Under hospital care but misses specialist appointments as too busy at work;<br>• Does little exercise;<br>• Misses hospital appointments for eye and kidney checks;<br>• Suffers from breathlessness, cannot walk up stairs, gets pains in legs if walks too far. Ends up being admitted to hospital for breathlessness as emergency. | • Diagnosed five years ago during routine health check, after sent weekly reminders and booked 10am Saturday appointment<br>• Under care diabetic nurse who sees him monthly at polysystem hub at a time convenient to him, checks his diet, exercise and treatment;<br>• Prescribed exercise vouchers for local recreation centre;<br>• Has eye and kidney checks at polysystem hub;<br>• Successfully loses some weight and suffers no complications of diabetes |

NHS London vision is for centralisation of specialist care and for routine care to be delivered outside of hospitals

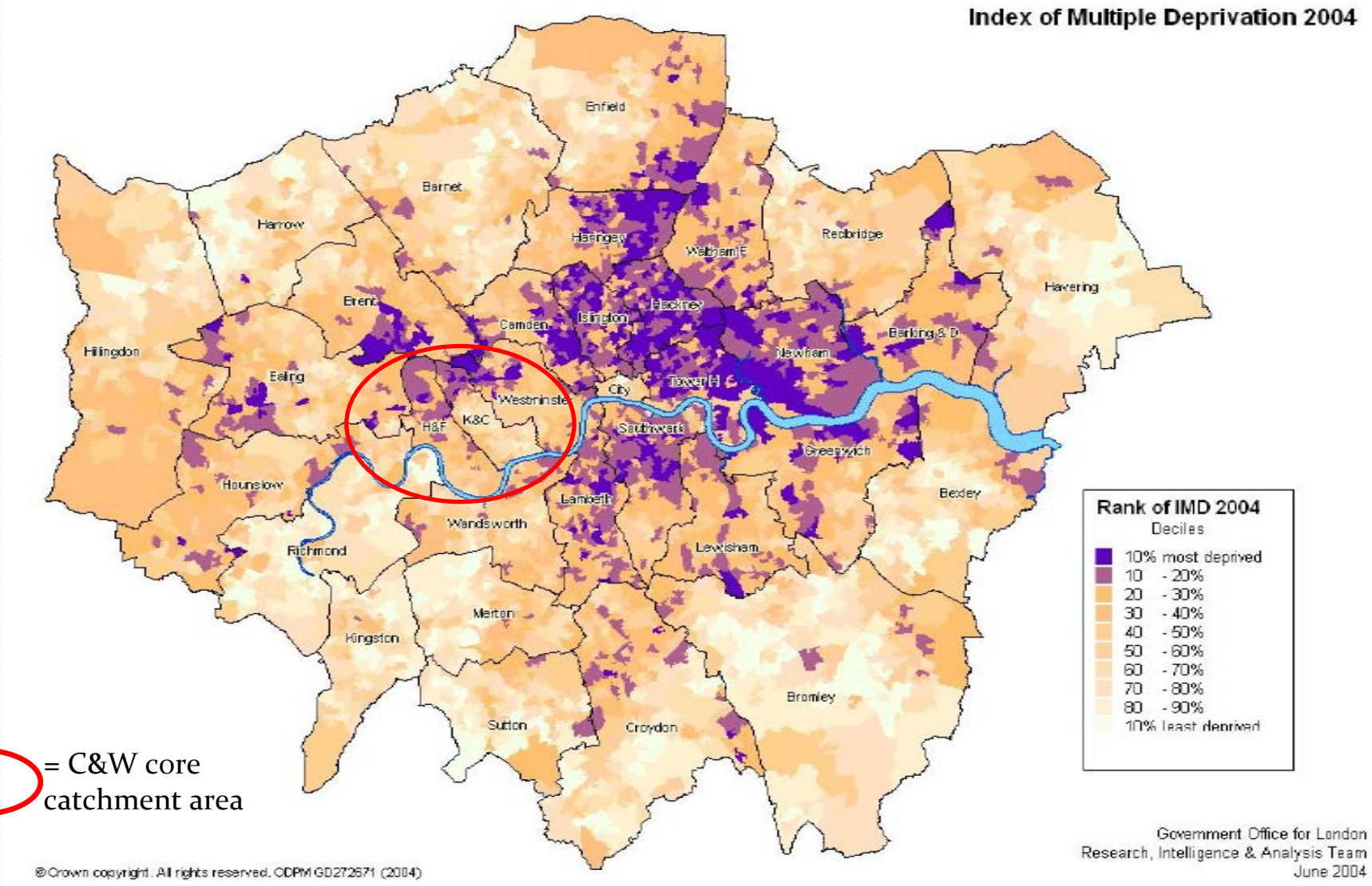
Public sector spending cuts will accelerate NHS London plans

Work by North West London PCTs likely to involve changes to hospitals

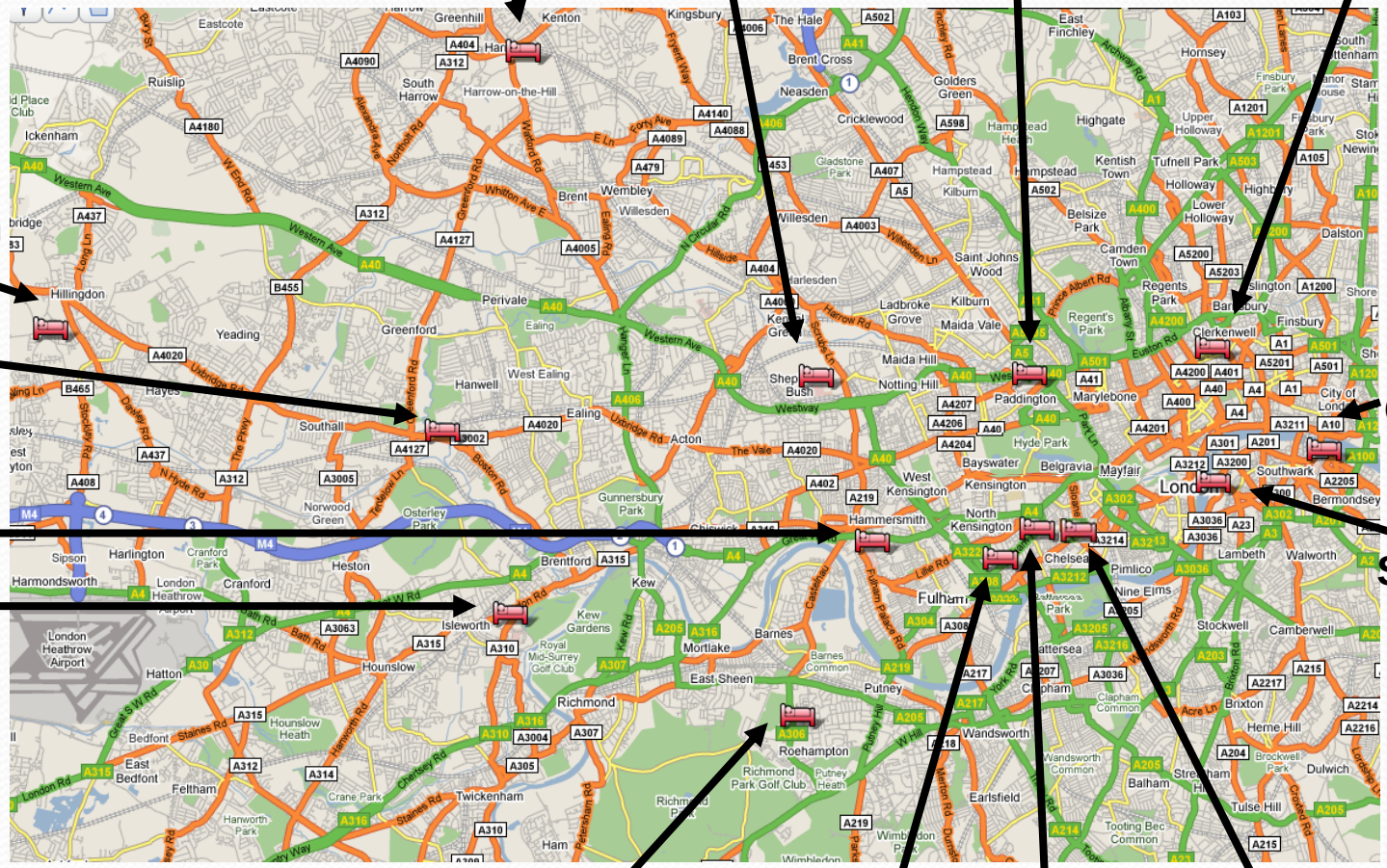
# North West London PCTs commissioned work to help implement *HfL* locally

- For C&W, impacts included:
  - Majority of Outpatient work to be done out of hospital
  - Urgent care centre reducing A&E visits by half
  - More maternity and children's services
  - Less emergency surgery
  - Reduced our income from £307m to £240m in 2012
- The work also looked at the options for different hospitals in North West London to merge

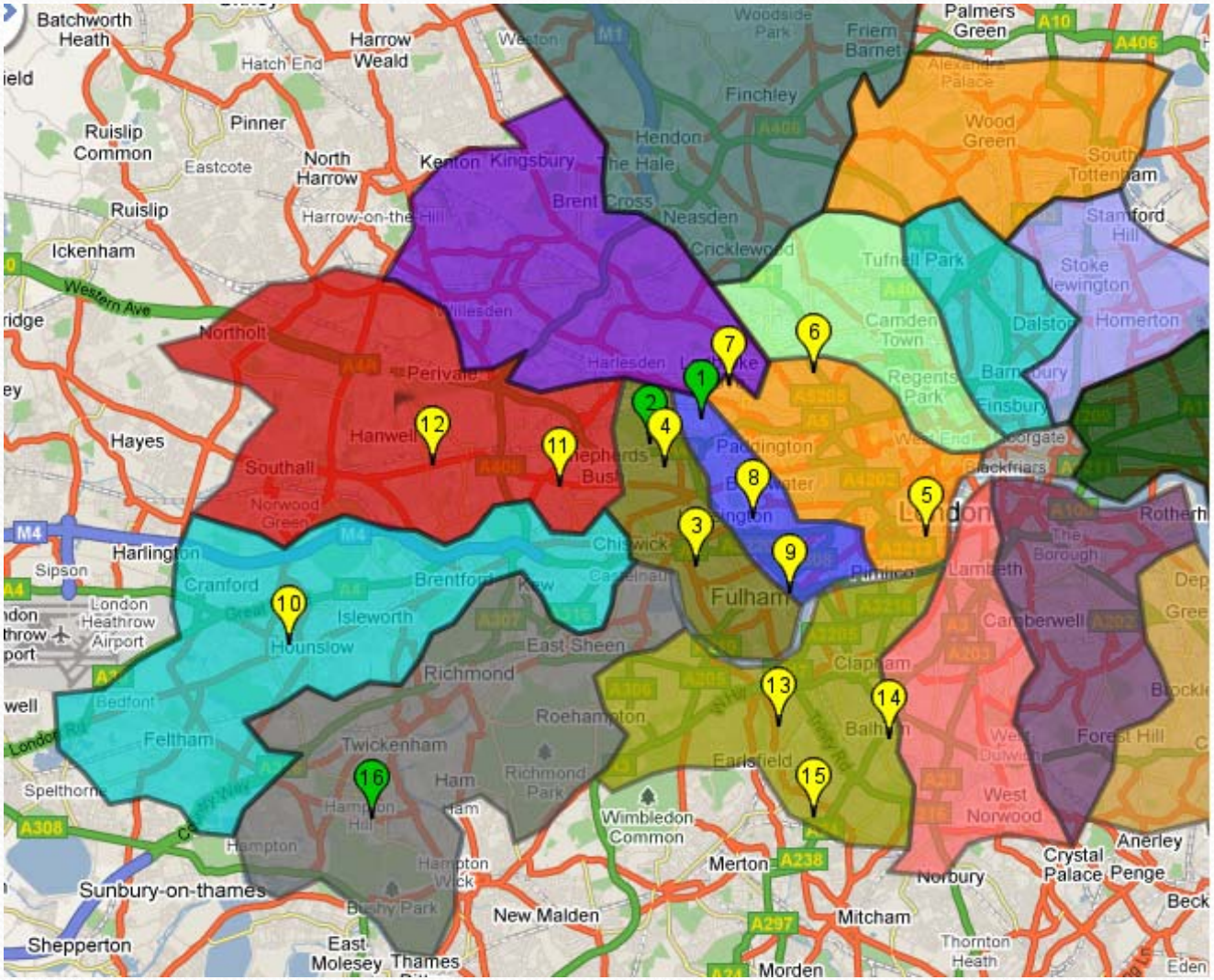
# We serve a population of ~400,000



# But there a number of hospitals in the vicinity



# And polysystem hubs opening




1. St Charles Polyclinic
   St Charles Hospital, K&C
2. Hammersmith Centre for Health
   Hammersmith Hospital, H&F
3. Fulham Centre for Health
   Charing Cross Hospital, H&F
4. White City (location tbc)
   White City Health Cente, H&F
5. South Westminster Centre
   Westminster
6. Hospital of St John & St Elizabeth
   Westminster
7. Queen's Park/Paddington (location tbc)
   Queen's Park Health Centre
8. Earl's Court (location tbc)
   K&C
9. South Chelsea (location tbc)
   K&C
10. Heart of Hounslow
    Hounslow
11. Acton Federated Polyclinic
    Ealing
12. West Ealing Integrated Polyclinic
    Ealing
13. Brocklebank Polyclinic
    Wandsworth
14. Balham Health Centre (hub)
    Wandsworth
15. St George's Hospital Polyclinic
    Wandsworth
16. Teddington Memorial Hospital Polyclinic
    Richmond & Twickenham

# We do not easily fit into any one of the *HfL* settings of care

**Home**

**Polyclinic**

**Local Hospital**

**Elective Centre**

**Major Acute Hospital**

(Including 3 AHSCs in London)

**Specialist Hospital**

# What kind of Trust could we be?

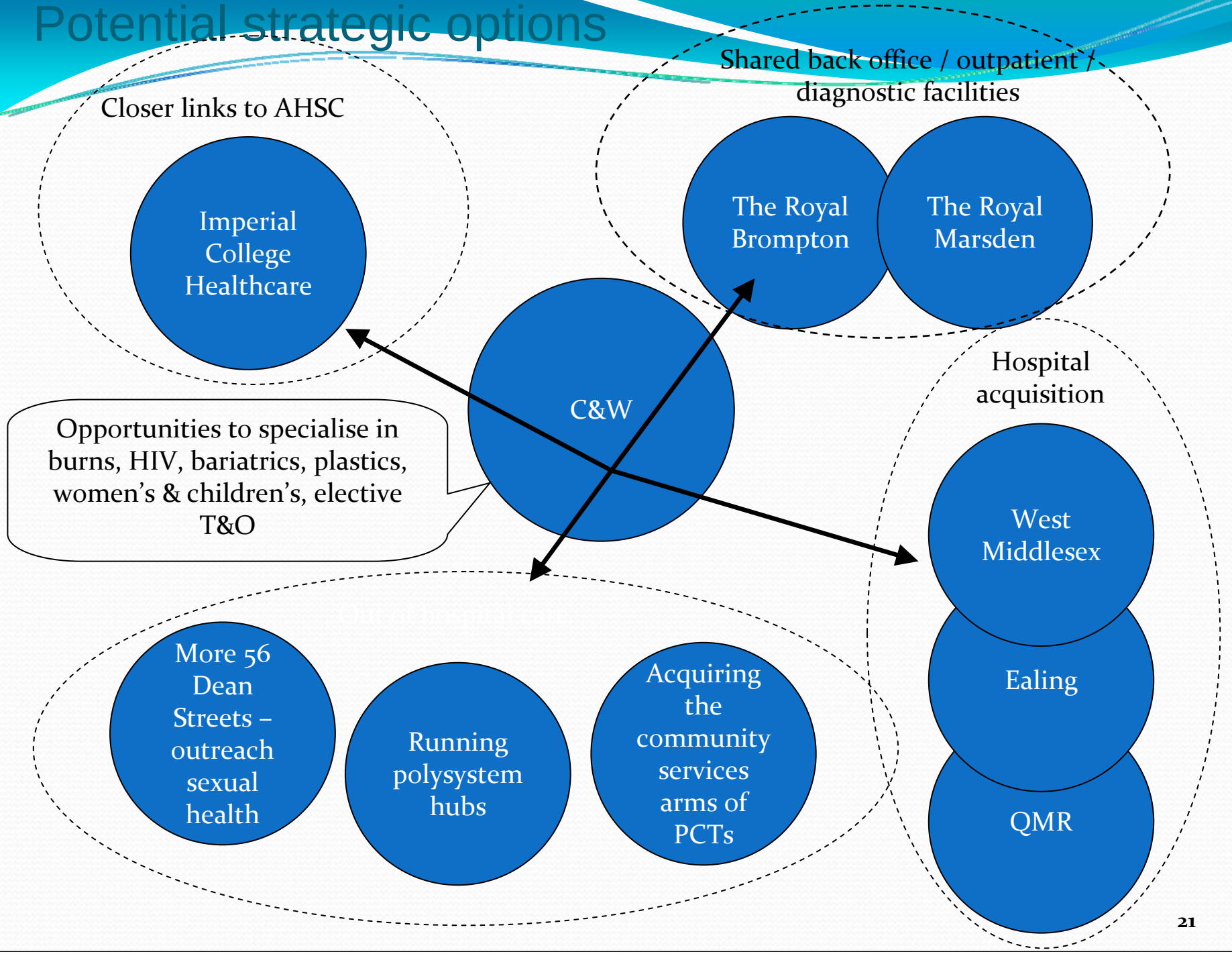
- We **cannot be a Major Acute hospital** – they serve a population of 0.5-1.0m, and in NWL Imperial will be one and one in outer NWL – either Hillingdon or Northwest London Hospitals.

- We **can be a specialist hospital** in services such as HIV, Burns, paediatrics, maternity as well as a **local hospital** for the local population. We could combine this with **a polysystem hub** within the hospital.

- However, may need to fight to retain emergency surgery on our site.

- What are our strategic options?

# Potential strategic options



# Summary

- As a Foundation Trust our future is secure but we cannot stand still
- Care will be increasingly delivered out of hospital in different ways
- We need to understand the impact of specialist services being centralised and routine care moving out of hospitals
- We may need to grow the size of our Trust

# Questions for the group

1. How can we make out of hospital care work?
   a. What would make this attractive for you?
   b. What would you be worried about?

2. What do you think of the various strategic options?

3. How can we engage the membership in discussing potential futures for the Trust?

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Council of Governors Meeting, 3 December 2009

| | |
|---|---|
| **AGENDA ITEM NO.** | 5.7/Dec/09 |
| **PAPER** | Who is who on the Council of Governors? |
| **AUTHOR** | Vida Djelic, Interim FT Secretary |
| **LEAD** | Vida Djelic, Interim FT Secretary |
| **SUMMARY** | This paper provides an overview of the membership of Council of Governors. It is intended to produce a list with more information about individuals and Governors will be invited to submit biographies. |
| **DECISION/ ACTION** | The Council is asked to note the paper |

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Membership of the Council of Governors

## Chairman, Prof. Sir Christopher Edwards

**Public Governors (8)**
Hammersmith and Fulham 2 – Christine Blewett
Kensington and Chelsea 2 – Lady Smith-Gordon
Wandsworth 1 – Mary Symons
*Wandsworth 2 – Vacant*
Westminster 1 – Ann Mills-Duggan
Westminster 2 – Martin John Lewis
*Hammersmith and Fulham 1 – Vacant*
*Kensington and Chelsea 1 – Vacant*

**Patient Governors (10)**
Walter Balmford
June Bennett
Chris Birch
Cass.J.Cass-Horne
Alan Cleary
Edward Coolen
Susan Maxell
Wendie McWatters
Jim Smith
Taryn Youngstein

**Staff Members (6)**
Allied Health Professionals, Scientific and Technical – Lucy Ball
Contracted – Jacinto Jesus
Medical and Dental – Brian Gazzard
Management – Carol Dale
Nursing and Midwifery – Sue Smith
Support, Administrative and Clerical – Sinead Jones

**Nominated Governors (10)**
Kings College – Alison While
NHS Kensington and Chelsea PCT – Edgar Moyo
NHS Hammersmith and Fulham PCT – Rosie Glazebrook
NHS Wandsworth PCT – David Finch
Royal Borough of Kensington and Chelsea - Frances Taylor
Royal Brompton and Harefield NHS Trust - Duncan Macrae
Royal Marsden NHS Foundation Trust - Nicky Browne
Westminster City Council – Cyril Nemeth
Westminster PCT - Catherine Longworth
*Imperial College, London – Vacan*t

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Council of Governors Meeting, 3 December 2009

| | |
|---|---|
| **AGENDA ITEM NO.** | 5.8/Dec/09 |
| **PAPER** | Invitation to work with the Care Quality Commission |
| **AUTHOR** | Vida Djelic, Interim FT Secretary |
| **LEAD** | Catherine Mooney, Director of Governance and Corporate Affairs |
| **EXECUTIVE SUMMARY** | Please find enclosed a copy of the letter from the Care Quality Commission inviting governors to be involved in all aspects of their work. |
| **DECISION/ ACTION** | To Council is asked to note the paper. |

Care Quality Commission
Finsbury Tower
103 – 105 Bunhill Row
London
EC1Y 8TG
Telephone: 020 7448 9299
Fax: 020 7448 9222
**www.cqc.org.uk**

21st October 2009

Dear Foundation Trust Board of Governors,

**Invitation to work with the Care Quality Commission**

This letter describes how the Care Quality Commission would like to work with you to improve the services we check on. We are the new national regulator for health, adult social care and mental health services.

We help to make sure people get better care, by driving improvement across health and adult social care, putting people first and championing their rights, and acting swiftly to remedy bad practice. We are committed to gathering and using knowledge and expertise and working with others, particularly with people who use services and their representatives. We enclose a leaflet that tells you what we do and the powers we have.

In June, we launched Voices into Action, our plan for involving people in our work. This includes working with Foundation Trust Boards of Governors. You can find out more about it at http://www.cqc.org.uk/getinvolved/involvingthepublic.cfm.

We are committed to listen to the views of people who use services and the public in everything we do. We know that without your help, we cannot properly check on services or make decisions about the quality of care being provided. There are three main ways we would like to work with you:

1. Sharing information - about what we are both doing to monitor services
2. Hearing about peoples' views of services and their experiences of care
3. Involving you directly in our work - such as, in deciding our approach and methods, and in monitoring services at local level.

We are committed to giving you feedback about what we have done with any information, views or experiences you have shared with us. The enclosed information sheet tells you more about how we would like to work with you.

We will be working with Monitor and the Foundation Trust Network to make sure we involve you in our work in the most effective ways.

We would also like to draw your attention to the following opportunities for you to help us:

**Join our sounding board for representative groups**

We will use face to face meetings, telephone discussions and email to get your advice on what we do and how we do it. Contact lucy.hamer@cqc.org.uk or clare.delap@cqc.org.uk if you are interested in taking part in the sounding board. You can get involved in a way that suits you.

**Tell us your experiences of health and social care services in your area**

We hope you will be able to tell us about your experiences of health and social care services during this year. We can use your experiences in our assessments of services and in deciding whether to register healthcare providers by April 2010. The information sheet enclosed tells you more about these.

**Giving you feedback**

A big thank you to those Boards of Governors who have sent information to the Healthcare Commission about the performance of your local health services for the Annual Health Check 2008-2009. The Care Quality Commission is continuing this work. We will contact you shortly to tell you what we did with the information you gave us.

We hope you found this useful and very much look forward to meeting you and working with you over the coming months.

Yours sincerely

**Barbara Young**
**Chairman**
**Care Quality Commission**

# Information sheet for Foundation Trust Boards of Governors

**October 2009**

The Care Quality Commission would like to involve Foundation Trust Boards of Governors in all aspects of our work. This information sheet lets you know how we would like to do this, and includes many of the ideas you have already given us about working together. We will update this information as our work develops.

## Telling us about people's views of services and experiences of care

We would like to hear about people's views of health and social care services and their experiences of care. We will use as much of the information you give us as we can. It might be from people who use services, their carers, members of the public or local user or community groups. It doesn't matter which services the information relates to, or how many services it covers.

Our staff are here to listen to you. You can talk to your local Care Quality Commission staff or send them written information at any time. Please ring our National Contact Centre on 03000 616161 to find out the names of the Local Area Managers in your local authority area. You can also email written information about people's views and experiences to our National Contact Centre at **enquiries@cqc.org.uk**.

## Information from your members

If you have any evidence from your membership about the quality and safety of health or social care services, we would be interested to hear about it. You can send any evidence to our National Contact Centre at enquiries@cqc.org.uk

## Assessing NHS services

You can send us any evidence you have about the quality of local NHS services. We will send you further guidance in the autumn about the aspects of quality and safety we are assessing this year.

Your information will help us to decide if local NHS service providers meet the requirements to register with us as a service provider from April 2010. Where relevant, it will also be used to inform our decisions about providers' compliance with the core standards assessment (previously known as the Annual Health Check), from April 2009 to April 2010.

**It will help us if you can send any information by the end of January 2010 to your local Care Quality Commission staff or to: enquiries@cqc.org.uk**

## Assessing primary care trusts and councils

You can send any evidence you have about how well primary care trusts and councils are finding out about the health and social care needs of people in your area, and how they buy the services to meet these needs.

We will send you more information about how we are assessing these commissioners for the period April 2009-April 2010. In the meantime, you can send any information that you think is relevant to the contacts given above.

## Registering independent healthcare services

You can send information to us about the quality of independent healthcare services (such as private hospitals, clinics and doctors and hospices) at any time, using the contacts given above.

## Special reviews and studies

We are starting work on reviews and studies about the following services and issues:

- How well are the healthcare needs of people (of all ages) in care homes being met?
- How well is the pathway of health and social care for people who have a stroke and their carers working?
- Health and social care for families with disabled children and young people.
- How well are the physical health needs of people with mental health needs and learning disabilities in hospital and residential settings being met?
- Are local services being commissioned (or put in place) that meet the different health needs of the local community, and that help those people most at risk of poor health?
- How well are councils responding to people's first contact with them?
- Is the economic downturn affecting the quality of care?

If you have any information or evidence related to these topics, please send it to us using the contacts given above. More information about these reviews and studies can be found on our website: **www.cqc.org.uk**

## Giving you feedback

### Annual health check 2008/09:

A big thank you to all the Foundation Trust Boards of Governors that contributed to the annual health check of NHS organisations for 2008/09. We will be giving you feedback about how we used the information you gave us. One of our local Care Quality Commission staff will contact you to set up a meeting later this year.

## Other ways to get involved

There are a number of other ways for you to get involved in our work.

### Consultations

You can take part in our consultations. For more information about our current consultations, please visit our website: **http://www.cqc.org.uk/getinvolved/consultations.cfm**

### Sounding board for representative groups

Join our new sounding board. You can get involved in different ways, to suit you. This will mainly use email to get your advice on what we do and how we do it. We may invite you to occasional meetings to discuss our work face-to-face. If you are interested in joining, please contact: **lucy.hamer@cqc.org.uk** or **clare.delap@cqc.org.uk**

### Foundation Trust Boards of Governors with special interests

As part of the sounding board, we would like to hear if you are particularly interested in certain services or areas of our work. You may like to help us develop areas of our work such as registering and monitoring service providers, assessing service commissioners, assessing mental health, social care, NHS or independent healthcare services.

You may have a special interest in the care given to certain local communities, groups of service users, such as children or older people, or about certain issues that affect them.

Please contact our public involvement managers: **lucy.hamer@cqc.org.uk** or **clare.delap@cqc.org.uk** to tell us about your interests.

## How you can find out more

If you would like to find out more about the Care Quality Commission, you can:

- Visit our website at **www.cqc.org.uk** to see the latest news and events.
- Sign up to our monthly newsletter by visiting our website: **www.cqc.org.uk/newsandevents/newsletter.cfm** or by ringing our National Contact Centre on 03000 616161.

We hope you find this information sheet useful. If you have any questions about the information it contains, or have other issues you want to discuss with us, please contact **enquiries@cqc.org.uk**. We look forward to working with you.

Care Quality Commission

# About the Care Quality Commission

**The Care Quality Commission** (CQC) is the independent regulator of all health and adult social care in England.

We regulate all health and adult social care services in England, whether they're provided by the NHS, local authorities, private companies or voluntary organisations. And, we protect the interests of people held under the Mental Health Act.

We make sure that essential quality standards are being met everywhere care is provided, from hospitals to private care homes, and we help them to improve. We promote the rights and interests of people who use services and we have a wide range of powers to take action if services are unacceptably poor.

## **Our vision** is of high-quality health and social care which:

- supports people to live healthy and independent lives;
- helps individuals, families and carers make informed decisions about their care; and
- responds to individual needs.

## **Our mission** is to make care better for people, by:

- regulating health and adult social care services to make sure services are high quality and safe, encouraging improvement and stamping out bad practice;
- protecting the rights of people who use services, particularly the most vulnerable and those held under the Mental Health Act;
- providing accessible, trustworthy information on the quality of care and services so people can make better-informed decisions about their care and so that those who arrange and provide services can improve them; and
- reporting to the public on how commissioners and providers of services are improving the quality of care and providing value for money.

## By high-quality care, we mean care that:

- is safe;
- has the right outcomes, including clinical outcomes (for example, do people get the right treatment and are they well cared for?);
- is a good experience for the people who use it, their carers and their families;
- helps to prevent illness, and promotes healthy, independent living;
- is available to those who need it when they need it; and
- provides good value for money.

**Our aim** is to make sure better health and social care is provided for everyone, whether that's in hospital, in care homes, in people's own homes, or anywhere else that care is provided.

## We do this by:

- registering, inspecting and regulating health and adult social care services;
- protecting the interests of people held under the Mental Health Act;
- working with those who provide services and those who arrange services locally (commissioners) towards improving those services;
- giving individuals, families and carers clear information about what care is available and the quality of services provided;
- taking action where services are unacceptably poor;
- reporting on how people arrange services locally to make sure high quality services are provided; and
- involving people who use services, and their families, in our work.

Throughout all of our work we focus on the rights, interests and experiences of people who use services. Our priority is to improve what happens to them as a result of the care they receive.

## Bringing together the independent regulation of health and adult social care

We bring together the regulation of health and adult social care in England. Before 1 April 2009 this work was carried out by the Healthcare Commission, the Mental Health Act Commission and the Commission for Social Care Inspection.

Having one regulator of health and adult social care helps to make sure there are consistent standards of quality across all services. It also helps to improve the way hospitals, care homes and social service providers work together for the benefit of the people who use their services.

By providers we mean those who actually provide services – for example hospitals and care homes.

**One regulator of health and adult social care helps to make sure there are consistent standards.**

## Registering with CQC

From April 2009 independent health care and adult social care services are registered with us under existing rules. And for the first time, NHS providers such as hospitals and ambulance services must be registered with us to show they are protecting people from the risk of catching infections such as MRSA. From April 2010 a new registration system means that health and adult social care providers must be registered with us to show they meet a wide range of essential quality standards. If they are not registered with us, they will not be able to operate.

Registration allows us to give the public the reassurance that, wherever they receive care or treatment, they can expect essential standards of quality of care. These standards make the system fairer and clearer and they make it easier for providers to be compared with one another.

## Working towards improving the quality of health and adult social care services

**We encourage improvements in services by helping to identify and share good practice.**

We promote improvements in the quality of care above and beyond essential quality standards. We do this by working with people who arrange local health and adult social care services – for example local councils and primary care trusts (commissioners) and those who provide them – for example hospitals and care homes (providers).

We encourage improvements in services by helping to identify and share good practice. Each year we carry out a series of reviews and studies of different aspects of care. They are guided by what people tell us is important to them. Our reviews and studies examine the entire service people receive, rather than one part of it. For example, a review might follow the experience of someone with dementia right through from seeing their GP, to their referral to hospital and then on to the social care support they might need when they leave hospital.

Our reviews also focus on how well local health and adult social care services are arranged, again by looking at the entire service people receive. Our assessments of this make a major contribution to overall assessments of the quality of local services. These overall assessments are called comprehensive area assessments.

# The assurance you need in health and social care

## Checking that organisations are meeting essential quality standards

As the health and adult social care regulator, our job is to make sure that providers continue to meet essential quality standards after they register with us. We do this by:

- analysing and inspecting services;
- asking providers to assess themselves; and
- collecting information to help us monitor how providers are performing.

If there is evidence of a serious and urgent problem that is putting people at risk, we will investigate and take immediate action if necessary.

## Providing information about health and adult social care services

Because we are independent, we can be relied on to provide information which is fair, accurate, easy to get hold of and which can be trusted. We report our findings fairly and truthfully. We listen to service users and providers. And we communicate our findings with everyone concerned, from service providers to policymakers and the public.

Our information helps people to judge the quality of their local health and adult social care services. It helps those who arrange and provide services to:

- compare their performance with others;
- see where improvement is needed; and
- learn from each other about what works best.

**Our information helps people to judge the quality of their local health and adult social care services.**

## Enforcing standards

**We ask people to tell us about their experiences of care services and to give us their views.**

If providers don't meet essential quality standards, or if we think that people's basic rights or safety are at risk, we take action. We have a wide range of enforcement powers, such as fines and public warnings, and we have flexibility about how and when to use them. We can apply specific conditions in response to serious risks. For example, we can demand that a hospital ward or service is closed until the provider meets safety requirements or is suspended. Or, we can take a service off the register if absolutely necessary.

## Involving the public

Throughout our work we make sure that the voices of people who use health and adult social care services are heard. We ask people to tell us about their experiences of care services and to give us their views. We make sure they are at the heart of our reports and reviews. In some cases we involve patients and their carers directly in working alongside our inspectors to give an expert user view of services.

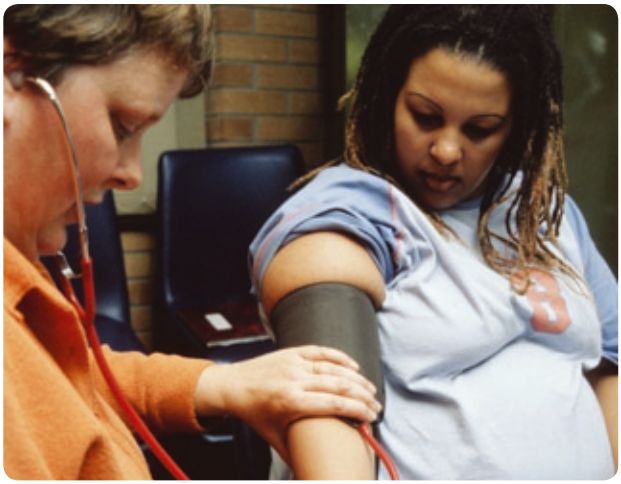
## Our work and human rights

Human rights are at the heart of our work. We promote and protect the rights and interests of everyone who uses health and adult social care, particularly the most vulnerable, for example people who are held under the Mental Health Act.

## Influencing policy and practice

We use our knowledge and experience of health and adult social care to inform government policy and local approaches to care. Through this work we make sure that the voices of people who use services are heard.

**Human rights are at the heart of our work.**



## Where we are

Our London headquarters is at Finsbury Tower, 103–105 Bunhill Row, London EC1Y 8TG.

Our nine regions cover the same areas as the Government Offices for the Regions and Strategic Health Authorities.

For more details on our regional offices, please visit our website at www.cqc.org.uk

## How to contact us

Phone: 03000 616161
Email: enquiries@cqc.org.uk