Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting

Hospital Boardroom
Chair: Prof. Sir Christopher Edwards
Date: 16 September 2010
Time: 3pm

Agenda

	PLEASE NOTE THE EARLIER START AT 3PM	Lead	Time
1	**GENERAL BUSINESS**		3.00
1.1	Welcome & Apologies	CE	
1.3	Declaration of Interests	CE	
1.4	Minutes of Previous Meeting held on 21 July 2010 (attached)	CE	
1.5	Matters Arising (attached)	CE	
1.6	Chairman's Report (oral)	CE	
2	**ITEMS FOR DISCUSSION/DECISION/APPROVAL**		3.10
	GOVERNANCE		
2.1	Presentation of Annual Report & Accounts 2009/10 (attached)	LB	
2.2	External Auditors' Report (attached)	HB	
2.3	Report of the Audit Committee (attached)	AH	
2.4	Re-appointment of the Auditor (attached)	AH	
2.5	Report on the external assurance dry run audit of the Quality Report year ended 31/03/2010 (attached)	HB	
2.6	Appointment of a new Non-Executive Director recommended from the Nominations Committee (attached)	CE	
2.7	Re-appointment of Non-Executive Directors (attached)	CE	
2.8	Re-appointment of the Chairman (attached)	CW	
2.9	Review of constitution (attached)	CE	
	COUNCIL OF GOVERNORS		4.10
2.10.1	Patient Governors: their role, duties and constituents (attached)	EC	
2.10.2	Governors' involvement in various sub-committees and activities (attached)	CE	
2.10.3	Proposed Audit of Governors' Skills and Experience (oral)	SS-G	
2.10.4	Meeting time (oral)	CE	
2.11	FTGA/FTN Development Day 23 July 2010 – feedback (attached)	CD	
2.12	Council of Governors Funding Report (attached)	VD	
	QUALITY		4.45
2.13	Quality Sub-Committee report (draft minutes of 3 September 2010 meeting attached)	CM	
	MEMBERSHIP		4.50
2.14	Membership Sub-Committee report (draft minutes of 2 September 2010 meeting attached)	CB	
2.14.1	Signage – Redevelopment of the hospital		
2.14.2	StartHere – Piloting Patient Information System		
2.15	Membership Development Action Plan update (attached)	SN	
2.16	Membership Report (attached)	SN	

	STRATEGY		5.05
2.17	Highlights of the White Paper (attached)	HL	
3	**ITEMS FOR INFORMATION**		
3.1	Finance Report – July 2010 (attached)	LB	
3.2	Performance Report – July 2010 (attached)	MG	
3.3	FTGA's Questions are the Answer – to be tabled	CM	
4	**ANY OTHER BUSINESS**		5.15
5	**DATE OF THE NEXT MEETING – 2 December 2010**		

PLEASE NOTE THAT THE ANNUAL MEMBERS' MEETING WILL FOLLOW AFTERWARDS

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 16 September 2010

AGENDA ITEM NO.	1.4/Sep/10
PAPER	Draft minutes of the meeting of the Council of Governors meeting held on 21 July 2010
AUTHOR	Vida Djelic, Interim Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper outlines a record of proceedings at the previous meeting.
DECISION/ ACTION	1. To agree the minutes as a correct record. 2. The Chairman to sign the minutes.

Council of Governors Meeting Minutes, 21 July 2010
DRAFT

Prof. Sir Christopher	Edwards	Chairman		CE
Eddie	Adams	Public	Kensington and Chelsea 1	EA
Lucy	Ball	Staff	Allied Health Professionals, Scientific and Technical	LB
Walter	Balmford	Patient		WB
Chris	Birch	Patient		CBir
Christine	Blewett	Public	Hammersmith and Fulham 2	CBlew
Cass	Cass-Horne	Patient		CC-H
Alan	Cleary	Patient		AC
Edward	Coolen	Patient		EC
Samantha	Culhane	Public	Hammersmith and Fulham 1	SC
Carol	Dale	Staff	Management	CD
Duncan	Macrae	Appointed	Royal Brompton and Harefield NHS Trust	DM
Brian	Gazzard	Staff	Medical and Dental	BG
Jacinto	Jesus	Staff	Contracted	JJ
Martin	Lewis	Public	Westminster 2	
Catherine	Longworth	Appointed	Westminster PCT	CL
Susan	Maxwell	Patient		SM
Charlotte	MacKenzie Crooks	Staff	Support, Administrative & Clerical	CMC
Wendie	McWatters	Patient		WMW
Sandra	Smith Gordon	Public	Kensington and Chelsea 2	SS-G
Frances	Taylor	Appointed	Royal Borough of Kensington and Chelsea	FT
Alison	While	Major Education Provider	King's College	AW
Taryn	Youngstein	Patient		TY

IN ATTENDANCE:

Heather Lawrence	Chief Executive	HL
Catherine Mooney	Director of Governance and Corporate Affairs	CM
Mike Anderson	Medical Director	MA
Matt Akid	Head of Communications	MAk
Vida Djelic	Interim FT Secretary	VD
Sian Nelson	Membership and Engagement Manager	SN
Richard Kitney	Non-Executive Director	RK
Charlie Wilson	Non-Executive Director	CW

1 GENERAL BUSINESS

1.1 Welcome & Apologies — CE

CE opened the meeting with a minute's silence to commemorate the death of Jim Smith, patient governor. BG said that the new HIV ward will be named after him.

CE welcomed newly elected governors to their first meeting of the Council of Governors and invited governors to introduce themselves.

CE noted apologies tendered: Paul Baverstock, Nicky Brown, Del Hosain, David Finch, Edgar Moyo, Cyril Nemeth and Sue Smith.

1.2 Announcement of results of elections — CE

CE welcomed five newly elected governors and noted that CB was re-elected for another term. The new governors are:

Public Governors
Hammersmith and Fulham 1 – Samantha Culhane
Kensington and Chelsea 1 – Eddie Adams
Wandsworth 2 – Del Hosain

Patient Governors
Paul Baverstock
Chris Birch – re-elected

Staff Governors
Support, Administrative and Clerical – Charlotte Mackenzie Crooks

1.3 Declaration of Interests — CE

None.

1.4 Minutes of Previous Meeting held on 21 April 2010 **CE**

The minutes of the previous meeting held on 21 April 2010 were agreed as a correct record of proceedings with the following changes:

- SM said it had not been minuted that the Council of Governors would discuss the strategy further and it was agreed that this should be added.
- P. 9, 1st para, 4th line, remove 'and Chelsea' from 'Kensington and Chelsea Town Hall'.

VD to correct the minutes in line with comments received. **VD**

AC said he had referred to a report to the Department of Health dated 30 January 2008 entitled "Quality Oversight in England – Findings, Observations and Recommendations for a New Model" and was disappointed that it was not on the agenda and had not been circulated. CE said that we will be having a discussion on the White Paper at the next meeting and it will be addressed then.

FT explained the delay to work at the front of the hospital. The contractors had run out of white paving. Completion of the work was being pursued. Concern about people smoking at the front of the hospital was expressed and there was a suggestion that there should be a smoking area at the back of the hospital.

1.5 Matters Arising **CE**

2.1.2/Apr/10 Lower Ground floor
CM said she had confirmed with Matt Akid, Head of Communications that the Trust Newsletter is sent to all governors.

2.3.1/Apr/10 Membership Sub-Committee
CM reported that the newsletter for August/Sept will be featuring the Council of Governors in the regular 'focus on' section. This includes included articles by some of the governors on their roles as governors.

We will take forward the idea of including what was covered at the meetings and further develop sections on how governors make a difference, including examples of projects that the governors have funded or been involved in e.g. the open day.

All other matters arising were as in the matters arising paper.

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

EC said he wanted to apologise for submitting his rough notes for discussion under any other business at the previous meeting but emphasised that the points raised were also views of other patients.

CE emphasised that as a general point we should discuss adverse experiences that we can learn from and not use the meeting to promote individual complaints.

EC said he had put forward an item on the role of the patient governors to the Agenda Sub-Committee and queried why it is not on the agenda. The Chairman confirmed that this would be discussed at the next meeting.

AC referred to the Monitor publication 'your statutory duties. A reference guide for NHS foundation trust governors'. ref. p.34 'what are the legal requirements?'

The document says that it is for the Board of Governors as a whole to appoint or remove a non-executive director, rather than a committee. This could leave our process open to challenge.

CE reported on the Nominations Committee. The committee had met on 16 July and that Cyril Nemeth, Sandra Smith-Gordon and he attended. Eleven candidates had been selected for a long-list. He asked that governors e-mail him or write to him if they are not happy with the process.

CE said that the FTGA Development Day on 23 July will be attended by the following governors: Edward Coolen, Carol Dale, Sue Smith, Edgar Moyo and Sian Nelson.

CE updated governors on the chelwest e-mail account progress and said that there has been a problem with the remote server and it should be resolved by end of the week. He reminded governors that this aims to facilitate contact between governors and members of their constituencies.

CE said there will be more detailed discussion at the next Council of Governors meeting regarding the White Paper and how we are going to be affected by GP commissioners, what it means and how the new NHS National Commissioning Board will work.

2 ITEMS FOR DISCUSSION/DECISION/APPROVAL

2.1 Strategy Update

HL said that she had the opportunity to meet with Andrew Lansley, Secretary of State for Health.

The three year Corporate Plan was agreed by the Board in May. Our vision is to provide a high quality patient-centred care to those using the specialist services. The Board agreed the Netherton Grove project and are expanding and modernising the hospital, and in particular the focus is on HIV and children.

In the future we will need to be 10% more efficient. We are looking at and winning work in new markets, e.g. specialist children's services, dermatology out of hospital. We are doing well and our reputation is growing and we need to continue this work.

The emphasis is on integrated care pathways and care close to home. There is a greater emphasis on competition and there are many hospitals in North West London. There is uncertainty around the structural transitions ahead.

Andrew Lansley wants the public to be given choice, with a system dedicated to improving quality and outcomes, with ring-fencing for public health. There will be more autonomy, accountability and legitimacy of commissioning at local level by GP consortia and local authorities. SHAs and PCTs will go.

There will be greater freedoms for Trusts and clinicians as social enterprises with more open but regulated NHS market system, e.g. removing the cap on private patients.

The emphasis is on exercise/fitness and early diagnosis.

The population of North West London is circa 400,000 and there are 14

hospitals. The plan is that by 2013 all NHS trusts either become or get managed by Foundation Trusts. Only Hillingdon Hospital is close to becoming a Foundation Trust so there are some challenges.

Regarding strategic options – although we want to provide care to the local community we also want to remain a specialist services hospital. We are collaborating with the Royal Marsden Hospital (RMH) and the Royal Brompton Hospital (RBH). The future is about new relationships and we are working with Great Ormond Street Hospital and St. Thomas and Guy's Hospital for paediatrics.

There is feeling that GPs commissioning will lead to more polysystems.

We have looked at acquiring another hospital and we considered it together with the RMH and the RBH.

HL believes that no radical changes are needed to our strategy but we need to place greater emphasis on clinician driven management and leadership skills. We need to engage more with patients and GPs.

In terms of next steps, we are reviewing how we are delivering on the corporate financial plan. We have planned to engage with GPs and find out what they need and how we can help. We also need to explore the opportunities and how we can help with the North West London strategic plan.

In response to CL's question regarding the 10% cost reduction HL responded that our management costs are low in comparison to most similar hospitals and this will be addressed in more detail in the next agenda item.

EC said there must be severe cuts in administration. CE responded that the problems in the health service are different from other public organisations and we will be relatively protected. Our funding will go up slightly while other public organisations will have reduced funding. The challenge is the increased need and advances in technology, which is costly.

AC asked HL to comment on the page 27 of the White Paper 'Liberating the NHS'. HL responded that our staff do feel liberated and we are rated in the top 20% of trusts in the staff survey for engagement. She pointed out that our paediatric and HIV services had been designed by clinicians. As for social enterprise she looked at this in South Africa a number of years ago but has only seen it in health visiting and district nurses in the NHS. She said she does not think it fits well with Foundation Trusts and may be more relevant to community services.

ML pointed out that we were in the top hospitals in the Dr Foster rating. He had been part of the clinical excellence award panels and was very impressed with some of our clinicians and what they had achieved.

BG said that staff are involved in quality of care we provide to patients. He said that there are great opportunities for providing joint pathways of care and his worry is that there will not be enough management available to support this. CB expressed concern about management being targeted as we cannot successfully do many things without managers. CE said he agreed that most organisations which are successful have very good management. EC asked what our management costs were. HL said it depended on how it was defined but it was about 4%.

In response to EC's questions HL responded that the hospital's consultancy fees are very low. CE said that the Trust had been asked to contribute £188k for funding for a project by McKinsey and had declined.

2.2 CIP Strategy Update

HL said that this had been partly covered. She said some savings were about improving productivity and some are about realising savings.

CBlew asked about the nursing skill mix. HL said that we need to review this and are looking at specialist nurses and management 'layers'.

HL said that we have communicated to all staff on why we need to make savings and to encourage their active involvement.

2.3 Council of Governors/Board of Directors Away Day **CE**

CE announced that we will have an Away Day in December. He said that there will be the opportunity to meet with the Board of Directors as some governors raised concerns that there is a lack of interaction between governors and Board members.

2.4 Quality Sub-Committee report **CM**

CM highlighted the main points of the draft minutes of the Quality Sub-Committee meeting held on 9 July.

She said that the Discharge Group has been refreshed and that governors, in particular, Jim Smith had been very keen for effective discharge to be one of our quality objectives. It had been agreed that governors will be represented on this group.

The governors had reported on patient experience and as a result we were able to make some immediate changes.

She said that we had conducted a staff survey earlier this year in order to obtain information for the quality account e.g. priorities. It was very successful and we plan to continue with this.

AC said he had mentioned at the last meeting the risk of intravenous injections being given via the spine and since the meeting he had been talking to various patients who would be undergoing a spinal procedure. He queried if there has been any progress in preventing this happening. MA responded that there were very tight controls in place on who can give such injections and how. A device to prevent this happening is not yet available. CE asked if we can look in to it.

MA to update re progress on spinal devices. **MA**

2.5 Patient Experience **HL**

HL outlined the results from the inpatient survey. The survey response rate was less that the average. Issues raised included the noise level and we are taking actions to improve it.

Jacinto Jesus organised a patient lunch for the executive team recently. Some

suggestions were made but the overall assessment was that the quality of food was good. HL said we pay less for food than some Trusts and to improve we may have to pay more.

HL said that our target is to be above the national average on five questions from the inpatient survey. These have been chosen as national indicators as part of the Commissioning for Quality and Innovation (CQUIN) payment framework.

CE said that it is unfortunate that there is a gap between conducting the survey and getting the results. The point of having the Patient Experience Tracker is getting the responses back quickly. HL said that we are aware of the issues highlighted in the survey.

2.6 Membership Sub-Committee report **CBir**

CBir said he was re-elected as a patient governor and carries out his duties as the Chair of the Membership Sub-Committee. He said that after the Annual Members' Meeting governors will have the opportunity to choose a new chair.

He pointed out that the membership of the sub-committee is open to any governors interested in joining and added that CMC has already joined and attended the previous meeting of the sub-committee on 8 July.

He noted that at the last meeting a tribute was paid to Jim Smith.

CBir said the Council of Governors received draft minutes of the sub-committee meeting held on 8 July and final minutes of 13 May meetings. The main discussion was around the strategy work plan which was more detailed and specific than before and more priorities focused.

2.7 StartHere – Piloting Patient Information System **CE**

CE referred to HL's earlier point about the government plans to dramatically improve information to patients.

StartHere is a charity which wants to work with a pilot organisation on their technology-based information service that acts as a single starting point from where people choose to access the information and services they need.
It provides information on a wide range of health, care-related and other social issues.

CE said that there will be a presentation to the Membership Sub-Committee at its meeting on 2 September and we will involve a governor on the steering group which will be set up soon.

The Council of Governors agreed to support a pilot of this system.

2.8 Membership and Engagement Strategy/Work Plan update **SN**

SN outlined the main points in the strategy and said that the revised strategy defines the membership community and describes how the Trust will grow the membership, ensure diversity and encourage engagement.

She outlined the work plan and said that 14 objectives have been agreed by the membership sub-committee. She noted that this was quite ambitious and encouraged more governors to join the committee. She highlighted some of the

objectives.

Information Zone
SN said that we have organised a drop in sessions for members and potential members to meet governors according to their availabilities.

One governor said she felt that the Information Zone is not located in a prominent position and that we may want to change it in the future. Other governors disagreed. SN said that a funding request for the Information Zone will be made to the Council later in the meeting.

Recruitment campaigns
SN said that the sub-committee review the work plan bimonthly. There is a mobile health clinic which aims to address some local health issues and access hard to reach groups. There is the opportunity for governors to help with recruiting new members in conjunction with this clinic.

CL asked how successful these campaigns are. SN responded that focused community campaigns are very successful. The Chelsea Football Club (CFC) was a project which visited the CFC seven times in the winter/spring session. There was positive uptake of users and user feedback was encouraging. Approximately 200 new members were recruited.

CBlew wondered about the logistics of governors trying to promote membership when the clinic is about a personal consultation. SN said that we are about to purchase an awning so that we have our own area rather than interfering in the patients health issues.

CE said that in the due course we will look at the funds spent and whether it is worthwhile.

Email communication with Members
SN said that we obtained 3000 e-mails following the request put in the Trust News letter in April. We used these e-mails to ask members to support the proposed abolition of the Western Extension of the central London Congestion Charging Zone and it has worked very well.

CE said it is very important that we now have e-mails of some of our members and we will be using it to communicate with them.

Website
SN said we are developing a webpage on the hospital's website on which we will publish results of the in-patient survey and we can also use it as an area where we promote information about governors.

2.9 Membership Report **SN**

SN outlined the main points of the membership report.

CB said that some figures in the report are worrying and some are puzzling. The good news was that in nine and a half months we had increased our patient membership by 107, from 6006 to 6113, but the bad news was that staff membership had gone down by 293, from 3340 to 3047, and public membership had dropped from 6135 to 6052, a decline of 83.

SN said there were problems with the confidential data transfer between HR and

Capita which resulted in the membership database not being updated regularly. She said this will be dealt with promptly.

SN said that the totals for analysis by age do not add up due to 'unknowns'. CE asked that this was included.

SN to include in the age group analysis how many are unknown age group patients, i.e. those who preferred not to disclose their age. **SN**

2.10 New Code of Governance and Trust Position **CM**

CM said that an analysis of the Trust's compliance status with the Code of Governance (the 'Code') was attached in Appendix 1. There is a requirement to publish a statement of compliance with the Code in the Annual Report.

The particular attention of governors was drawn to the following sections of the Code: B1.8, B1.5 and D.1.6.

AC said that most of the information in the Trust's constitution predates the blue book guide 'Your statutory duties: Reference guide for NHS foundation trust governors' and questioned the validity of it.

CE said that we have discussed the need for changing the constitution and there is an established procedure. There is also a time issue as changes have to be agreed by the members and this is usually done at the Annual Members' Meeting.

AC asked if the Code is a legally binding document. CM said that it is not, it is a Code and we seek to comply and are required to declare in our annual report where we do not comply. CE said that last year we publicly stated that we were not prepared to comply with one point of the Code (fixed term contracts for executive directors) and we had good reasons for not doing it. This has been removed in the revised Code.

CE clarified that we are responsible to Parliament but not to the Secretary of State.

2.11 Funding Report **CM**

VD said that part A of the funding report provides up to date information on projects to which money has been allocated and that there is approx. £48k left to be spent for the remainder of the financial year.

SN said that part B of the funding report relates to the Information Zone and a request to install an electronic message board and picture board.

WMW and SM said that they have done four hours in the Information Zone and it did not work to their expectations as the location is not right. People who come to the hospital are busy and they suggested it should be located in front of the escalators. SM said they managed to complete two to three membership forms.

CB said he disagreed as he felt the location was right but it has not been publicised as yet. He felt that once the electronic board was up and running it would begin to work. We need to publish dates on the website and on the screen in the information zone.

EC suggested an e-mail to members informing them about meeting governors. SM suggested we should put a leaflet in the next mail out so that all members are aware.

CE thanked the governors for trying out this process.

The Council agreed to the funding request.

CM said that part C of the budget report provides information about a quality award which was discussed and approved by the quality sub-committee.

The award aims to raise awareness of the three strands of quality i.e. patient safety, effectiveness and patient experience, and to reward achievements.

She asked that that in addition to £2k the governors approve an additional £400 for a prize for the staff survey, assuming £100 every quarter.

ML said that it is very good idea and wondered if we could link this to the seasonal conference and the award could get presented at the end of conference. CMC expressed concerns that we might possibly be limiting the attendance as the conference is mainly aimed at nurses. HL said this could be reviewed. ML suggested that it is called the 'council of governors quality award'. CC-H suggested we have a statue.

CE concluded that it is worthwhile doing and we can discuss at a later stage where it gets presented.

HL emphasised that the award is open to anyone to contribute no matter who the employee is.

The Council approved funding of the quality award.

2.12 Annual Members' Meeting - Proposal 2010 Report **MA**

MAk said that the Annual Members' Meeting (AMM) will be held on 16 September in the restaurant canteen. The hospital school is relocating to the 1st floor and the plan is to have an official opening at 2pm on the same day and to invite governors to attend.

The format of the AMM is set as a presentation by the Chairman, Chief Executive, Director of Finance and one governor.

MAk invited governors to volunteer and send their responses to VD. **All**

MAk pointed out that in the last 2 years we had done a paediatric DVD for children's surgery and we would like to do something similar this year.
HL pointed out that it is good to show other expertise we have e.g. sexual health and HIV.

It was agreed to have a DVD but the topic remains to be decided.

VD said that WB who left the meeting earlier wanted to suggest use of the PET as he felt it worked very well with at the Open Day. MAk responded that this has already been arranged.

2.13 Council of Governors Performance Evaluation Report **CE**

CE thanked governors for their comments on the performance and said that there are some that he needs to take into account as Chair although he noted some contradictory comments.

AC said that time allocation for reports should go. CE responded that the time allocated is purely indicative but if there is no time allocation it means the meeting could massively over run.

AC said that governors should have the right to put something on the agenda e.g. the Joint Commission International Report 2008 to the Department of Health titled 'Quality Oversight in England – Findings, Observations and Recommendations for a New Model' he requested to be put on the agenda for July's meeting.

CE responded that we have moved away from the previous arrangements where the Council of Governors did not owe the agenda. Now we have the Agenda Sub-Committee who meet and agree the agenda. We try to manage it so that there are not too many items for discussion and to be able to complete them within the time given for the meeting. He emphasised that the agenda sub-committee is open, to anyone who can come or submit an item.

EC asked about an issue he raised under any other business at the last meeting relating to governors visiting patients. CE responded that this was discussed by the Executive and they take the view that we cannot allow random visits which can affect functioning of wards and a system is needed.

EC suggested that we might save money by decreasing the circulation of Trust News to members.

HL said it is fundamental to have ability to communicate with staff to have a monthly trust news and feedback is that it is very good. CBlew said that the role of the Council is to hold the Trust executive to account, this is not our decision to make, our role is not about the detail but about having a strategy and this is an important principle. It is for the executive to make decisions but not the Council of Governors.

FT asked if governors can suggest items for Matt Akid to include and CE confirmed this.

CE said that there will be the opportunity for more interaction between the Board members and governors at an Away Day which will be organised in the autumn. He said we needed to consider the report and whether we can do some things better.

CE noted Walter's points relating to the performance report as Walter had to leave earlier.

2.14 Appraisal of the Chair and NEDs* **CE**

This item was taken as read.

2.15 Open Day Evaluation Report **MA**

MAk outlined the report and said that over 1,500 people visited the hospital on the Open Day. We used the Patient Experience Tracker (PET) to evaluate the

event and had asked visitors, staff and the Council of Governors to rate it.

MAk pointed out that the Council of Governors generously supported the event and funded it from its budget.

CE said everyone felt the event was excellently organised.

AC asked if we keep a box of suggestions for improvement for the future events. MAk responded that we do and consider both positive and negative comments.

CBir said he was misquoted in his response and that he said that there were 'slightly fewer governors' rather than 'slightly less'.

2.16 Proposed abolition of the Western Extension of the Congestion Charge Zone

MAk outlined the background to the paper.

He said that we have e-mailed all Trust members and raised awareness with staff and stakeholders about the consultation process on the proposed abolition of the Western Extension of the central London Congestion Charging Zone.

EC said he felt that the congestion has increased as a result of the extension of charging zone.

CE noted that there are different opinions. The Members' Council (now called Council of Governors) supported the abolition in 2007 but he noted that there are some individual views. From the hospital's perspective the extension of the congestion charging zone has an adverse impact on its services, and there will now not be any exemptions.

EA said he feels that putting congestion is more of a political than environmental issue and there should be an environmental alternative.

EC queried if governors can express their individual views over this. CE responded that in responding to the consultation as a Trust we should be considering the perspective of the hospital.

CBir said he agreed with the EC and EA and felt that imposing the congestion charging resulted in less air pollution and less congestion. The hospital is well served by public transport.

CE said that if one looks from the perspective of a parent with a sick child who needs to get to a hospital you would disagree with the extension. CBlew said she agrees with the Chairman and said that we need to look at what is best for patients, parents, carer, etc

CE said that on balance the western extension is not a good thing for the hospital especially in the increasingly competitive environment.

3 ITEMS FOR INFORMATION

3.1 Finance Report – May 2010 **LB**

This item was taken as read.

3.2 Performance Report – May 2010 **LB**

This item was taken as read.

3.3 Annual Report including Quality Report (Account) **MA**

A copy of the Annual Report including the Quality Report was handed to governors on the arrival to the meeting.

4 ANY OTHER BUSINESS **CE**

CBlew said that the PCTs have a list of procedures that they will not fund. This issue was brought to the Maternity Services Review Committee with respect to caesarean sections. She wondered if the Board had a position on this. She also was interested to know where the evidence for the list comes from and whether patients had been consulted.

CE said we need to understand the need to save money. PCTs have to decrease staff by 66% and will not be prepared to discuss this. We need to work with GPs going forward.

HL said that Zoe Penn, Divisional Medical Director, is actively involved in discussions. She is confident that when we exclude high risk pregnancies there will not be a problem.

SM said that exclusions for high cost drugs was mentioned in the contract summary. She was concerned that this may impact on safety and patient experience if patients are put on less effective drugs. CE said that this referred to exclusions from Payment by Results rather than exclusions for prescribing.
Further information would be provided to SM. **CM**

EC made a reference to a number of papers governors receive prior to the Council meeting and that it is time consuming to read them and suggested that it gets cut down.

CE said that WB had suggested that the meeting time is extended. CE suggested that governors are consulted on this and the preferred start time of the Council meetings.
VD to consult governors. **VD**

5 DATE OF THE NEXT MEETING

The next meeting of the Council of Governors will be held on 16 September 2010 at 3pm and will be followed by the Annual Members' Meeting at 5.30pm.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 16 September 2010

AGENDA ITEM NO.	1.5/Sep/10
PAPER	Matters Arising from the meeting of the Council of Governors meetings held on 21 July 2010
AUTHOR	Vida Djelic, Interim FT Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper lists matters arising from previous meeting and the action taken or subsequent outcomes.
DECISION/ ACTION	The Council of Governors is asked to note the matters arising and the updates.

MATTERS ARISING
Council of Governors Meeting
Hospital Boardroom
Chair: Prof. Sir Christopher Edwards
Date: 21 July 2010
Time: 4:30 – 6:30 pm

Ref	Description	Lead	Subsequent Actions or Outcomes
1.4/Jul/10	**Minutes of Previous Meeting held on 21 April 2010** **VD to amend minutes in line with comments received.**	**VD**	Completed
2.4/Jul/10	**Quality Sub-Committee report** AC said he had mentioned at the last meeting the risk of intravenous injections being given via the spine and since the meeting he had been talking to various patients who would be undergoing a spinal procedure. He queried if there has been any progress in preventing this happening. MA responded that there were very tight controls in place on who can give such injections and how. A device to prevent this happening is not yet available. CE asked if we can look in to it.		**Update from Dr. Nick Fauvel, consultant anaesthetist:** There has been cases of harm and death that have occurred over the years from wrong drug administration into spinal and epidural spaces. The NPSA has been attempting to reduce the risk of similar tragic mistakes. To date it has defined important process change in care delivery (for instance for administration of intrathecal chemotherapy) apparently with good effect. The NPSA is now pushing device manufacturers to change the connectors on the relevant devices to reduce the risk further. In concept the idea is simple: move from the Luer connector that has been the universal standard for a century, shared across lots of devices, to a unique connector for devices used for lumbar puncture, spinal and epidural injection.

			Earlier this year, frustrated by the reluctance of the manufacturers, who have been dragging their collective feet for about a decade, NPSA unilaterally announced a deadline of April 2011 for Trusts to implement changeover to devices with non-Luer connectors, (despite no such devices being available at the time of the announcement!) This has focused the (competitive) minds of industry. We now have the first indication of the device manufacturers' response, together with the NPSA's required Trust approach to implementation which has just been published. The Trust will be addressing this.
	MA to update re progress on spinal devices.	**MA**	
2.9/Jul/10	**Membership Report** **SN to include in the age group analysis how many are unknown age group patients, i.e. those who preferred not to disclose their age.**	**SN**	This is reflected in the Membership Report agenda item 2.16.
2.12/Jul/10	**Annual Members' Meeting - Proposal 2010 Report** The format of the AMM is set as a presentation by the Chairman, Chief Executive, Director of Finance and one governor. **MAk invited governors to volunteer and send their responses to VD.**	**All**	Completed
4/Jul/10	**Any other business** SM said that exclusions for high cost drugs was mentioned in the contract summary. She was concerned that this may impact on safety and patient experience if patients are put on less effective drugs. CE said that this referred to exclusions from Payment by Results rather than exclusions for prescribing. **Further information would be provided to SM.**	**CM**	Information has been provided to SM and she will advise on any further action she feels is required.

	CE said that WB had suggested that the meeting time is extended. CE suggested that governors are consulted on this and the preferred start time of the Council meetings. **VD to consult governors.**	**VD**	Completed

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 16 September 2010

AGENDA ITEM NO.	2.1/Sep/10
PAPER	Presentation of Annual Report & Accounts 2009/10
AUTHOR	Lorraine Bewes – Director of Finance & Information
LEAD	Lorraine Bewes – Director of Finance & Information
EXECUTIVE SUMMARY	This report sets out the annual accounts for the year ended 31st March 2010 and the auditor's report thereon along with other statutory information required to be disclosed by NHS Foundation Trusts. This report was laid before Parliament in June 2010. In accordance with paragraph 28 of Schedule 7 of the Act and section 17.6 of the Constitution, this report is presented to the Council of Governors.
DECISION/ ACTION	The Council is asked to adopt the report.

Annual Report & Accounts 2009/10

Choose Chelsea and Westminster

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

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

Chelsea and Westminster Hospital NHS Foundation Trust

Annual Report & Accounts 2009/10

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Introduction

About this report

Our annual report follows best practice in corporate reporting by articulating our strategy, reporting back on our performance against strategic objectives and national targets, and presenting information about our service and financial performance transparently and honestly.

The structure of the report is as follows:

- **Introduction**
  Statements by the Chairman and Chief Executive

- **Strategy**
  Our strategic vision, performance against corporate objectives 2009/10 and details of our corporate objectives 2010/11

- **Quality Report**
  Articulating our commitment to providing quality care for all patients and reporting back on our performance against priorities for quality improvement agreed by the Trust Board of Directors

- **Performance Report**
  Including our performance against national targets

- **Governance Report**
  Including details of the Board of Directors, Council of Governors and Foundation Trust membership

- **Statutory Information**
  Other information required to be included in the annual report by Monitor, the independent regulator of Foundation Trusts, including this year for the first time major new sections on Sustainability/Climate Change, Equality & Diversity, Staff Survey and Regulatory Ratings

- **Finance**
  Including the accounts

A commitment to quality and quality improvement underpins our corporate objectives and this annual report—we hope you enjoy reading it.

Credits

This annual report has been produced in-house by Chelsea and Westminster Hospital NHS Foundation Trust:

Content & Articles
Matt Akid
Head of Communications

Design & Layout
George Vasilopoulos
Web Communications & Graphic Design Manager

The Quality Report was written by Catherine Mooney, Director of Governance & Corporate Affairs, with contributions from a wide range of staff throughout the Trust.

Chairman's statement

Everyone knows that, despite the political commitment of the new Government to protect the NHS, the economic downturn will place major pressures on healthcare in the years ahead.

However, as a Foundation Trust with a proven track record of providing high quality care in new ways, we are well placed to rise to this challenge.

The active involvement of our 15,000 patient, public and staff Foundation Trust members—as well as their elected representatives on our Council of Governors—is vital to our future success and it was pleasing to see how we made this aspiration a reality in 2009/10.

56 Dean Street, our new HIV and sexual health centre in Soho, was made possible because as a Foundation Trust we could retain our financial surplus and invest it in the development of this state-of-the-art modern facility.

A user group including patients and Governors helped plan the development of this centre and it is now delivering services where and when patients want them—including at weekends and during the evening.

Little more than a year since it opened in March 2009, 56 Dean Street is now the busiest HIV and sexual health centre in London.

Governors and Foundation Trust members also supported the Trust's successful bid to be designated as a stroke unit. A capital scheme has expanded its capacity and our stroke services are ranked third best in the country by the National Sentinel Stroke Audit.

Parents and children who use our paediatric services were involved before, during and after our successful bid to be designated as the lead centre for neonatal and specialist paediatric surgery in North West London.

Chelsea and Westminster is a provider of specialist services for patients from all over London, South East England and beyond and general acute services for our local community. It is also a centre for teaching and research.

As a clinician and academic, I was delighted that we led a successful bid to establish and host the North West London Health Innovation and Education Cluster (HIEC). This new partnership aims to ensure that patients receive better treatment by promoting innovation, quality and productivity through training and education of healthcare staff.

We also host the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Northwest London which aims to enable the rapid introduction of new, effective treatments for a wide range of medical conditions.

Finally, I would like to congratulate Trust Chief Executive Heather Lawrence who was awarded an OBE in the New Year's Honours list for services to healthcare.

Heather has been key to the success of Chelsea and Westminster as Chief Executive since 2000 and she has also made an outstanding contribution to the wider NHS, most recently as a member of the Prime Minister's Nursing and Midwifery Commission.

Few deserve recognition more than Heather who has guided the Trust to financial stability, Foundation Trust status in 2006, and a reputation as one of the consistently best performing NHS organisations in England.

I am confident that, with Heather's strong and visionary leadership of our outstanding team, Chelsea and Westminster has a bright future despite the challenging economic times that undoubtedly lie ahead for the NHS.

Professor Sir Christopher Edwards
Chairman

Chief Executive's statement

2009/10 was a successful year for the Trust thanks to the commitment of all our staff.

We achieved a double 'Excellent' rating for both 'Quality of Services' and 'Quality of Financial Management' in the 2009 NHS annual performance ratings, placing us among the top 9% of NHS trusts. We expect to retain a double 'Excellent' rating for our performance in 2009/10 when the Care Quality Commission publishes the 2010 ratings in October.

Chelsea and Westminster was rated as the fourth best performing hospital in England for patient safety in the Dr Foster Hospital Guide 2009 and we continued to treat 95% of outpatients and 90% of inpatients within 18 weeks of GP referral.

We met, and indeed exceeded, Care Quality Commission targets to minimise MRSA bacteraemia and *Clostridium difficile* infections—no patient admitted for planned surgery in 2009/10 contracted MRSA—while the National Patient Safety Agency's Patient Environment Action Team (PEAT) assessment rated our hygiene standards as 'Excellent'.

However, we are not complacent and we recognise that from time to time there are shortcomings in the care and treatment that some patients receive—90% of respondents to the 2009 national inpatient survey rated their experience at Chelsea and Westmisnter as 'Excellent', 'Very good' or 'Good' but we want 100% of patients to have 'Excellent' care.

I believe passionately that the litmus test of any hospital is for every member of staff to ask themselves—would I want my loved ones treated here? If the answer is yes, we know that we are getting it right.

In 2009/10 we introduced the Patient Experience Tracker to gather 'real-time' patient feedback and rolled out the *Releasing Time to Care—The Productive Ward* programme to ensure that our frontline clinical staff spend more time with patients.

Over the last year we have also worked with staff and women to improve our maternity services and we are proud of the improvements that our midwives, obstetricians and the rest of the team have made by working together and listening to women who use our service—87% of women now rate our maternity care as 'Excellent', 'Very good' or 'Good'.

This year we are focusing on our medical wards to ensure that we communicate well and deliver compassionate care to our often very frail patients at all times.

Strategically we have anticipated changes to the NHS in London by repositioning ourselves as a high performing organisation that not only provides high quality specialist services and popular local services but also has the flexibility to provide services in the community.

In 2009/10 we won competitive tenders to provide community dermatology and gynaecology services in Westminster, established 56 Dean Street as a cutting edge HIV and sexual health centre in the heart of Soho, and were named as the 'preferred provider' for a new Urgent Care Centre co-located with Chelsea and Westminster A&E.

NHS organisations will need to be flexible and adapt to a very different political and economic environment by delivering services in new and innovative ways and so I am delighted that Chelsea and Westminster has a strong track record in doing just that.

We are making 10% cost savings in 2010/11 to ensure that we retain the financial stability that has underpinned our success while at the same time investing in a major redevelopment of the hospital.

This redevelopment will enhance our reputation as a provider of specialist services by delivering state-of-the-art facilities for children, HIV patients and outpatients.

Despite the economic downturn, I believe we have an opportunity to create an exciting future for the Chelsea and Westminster 'brand' as a guarantee of excellence in clinical care and patient experience—wherever we provide services and whatever new partnerships and alliances we forge with other providers and GPs.

I look forward to working with colleagues on the Board of Directors and staff at Chelsea and Westminster to help build that future.

Heather Lawrence

Heather Lawrence OBE
Chief Executive

Strategy

Our strategic vision

Strategic approach 2009/10

The Trust's strategic vision in 2009/10 was as follows:

"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."

Our strategic service objectives in 2009/10 were as follows:

- To be a provider of specialist services, building on our existing excellent reputation in HIV, burns care and high risk maternity, and developing our role as a designated centre for neonatal and specialist paediatric surgery, and stroke

- To be a provider of local services for our local population, including delivering more community-based services in specialties such as dermatology, musculoskeletal and diabetes, in collaboration with our primary, community and secondary care colleagues

Strategic developments 2009/10

The Trust developed its reputation as a provider of specialist services in 2009/10:

- Following a competitive tender process, we were designated as the hub of complex paediatric and neonatal surgery in North West London and lead organisation for the specialist paediatric surgical network in the sector—we have developed a federated model of care with key partner organisations including Great Ormond Street Hospital, Guy's and St Thomas' NHS Foundation Trust and Royal Brompton & Harefield NHS Foundation Trust

- In support of this expansion of paediatrics, the Trust was granted planning permission for a £39 million redevelopment of the main hospital site to improve the patient environment for children, HIV patients and outpatients in particular—work started on site in April 2010

- We achieved NHS Litigation Authority risk management standards in Maternity at Level 2 following an assessment in February 2010

- We refurbished our Neonatal Intensive Care Unit to expand its capacity to 42 cots in support of our high risk maternity and complex specialist paediatric patients

- The Assisted Conception Unit was refurbished to improve the environment for patients

- We were designated as a Stroke Unit by Healthcare for London and a capital scheme has expanded the unit to 22 beds

- 56 Dean Street, our new HIV and sexual health centre in Soho—which was officially opened in May 2009—has cemented the Trust's reputation as a leader in this field and is now the busiest HIV and sexual health centre in London

The Trust developed its reputation as a provider of local services, including delivering more community-based services in 2009/10:

- We successfully bid to become the provider of community dermatology and gynaecology services in Westminster—both services are now operational and proving popular with GPs and patients by offering the Trust's expertise in community settings closer to where people live

- An innovative new community mobile health clinic was launched in 2009/10, providing a range of health screening in a purpose-built mobile unit on matchdays at Chelsea Football Club—this initiative was initially targeted at men, who traditionally seek health advice less than women, but the aim is for the mobile health clinic to be used in a variety of community settings targeted at different patient groups

- We have worked closely with NHS Kensington & Chelsea in support of the national and regional drive to reduce inappropriate and unnecessary A&E attendances, and we have been designated as the 'preferred provider' for an Urgent Care Centre—this new facility, which will be co-located with the A&E department at Chelsea and Westminster, is due to open during 2010/11

Refreshing our strategic vision

The Trust's strategic vision was formed during our application for Foundation Trust status in 2006.

Not only has the landscape of the NHS environment within which we operate changed markedly since 2006 but also we require a robust strategy to cope with the effects of the economic downturn on the public sector.

During 2009/10 the Board of Directors engaged with the Council of Governors—elected representatives of patients, members of the public living in our four local boroughs, and staff, and nominated representatives of stakeholder organisations—to refresh our strategic vision.

The Trust's strategic vision for the next three years is as follows:

"To provide high quality patient-centred care for our local population and those using our specialist services, delivered by a modern workforce in a range of settings along integrated pathways of care."

Our strategic objectives to support the vision

Strategic objectives in support of our updated strategic vision are as follows:

- To improve quality—patient safety, clinical effectiveness and patient experience
- To streamline our administrative processes—for example, the use of technology to deliver our vision of an 'airport' style facility to enhance the patient experience in outpatients
- To foster an environment of strong clinical leadership
- To work collaboratively through networks and in partnership with other providers
- To provide world class teaching and research
- To deliver more care in community-based settings in close liaison with GPs and other primary and community care colleagues
- To challenge traditional ways of working to ensure an efficient and 'fit for purpose' organisation that is financially sustainable

The Trust is operating in challenging economic times for the NHS—we have established the *Fit for the Future* programme to make 10% cost savings in 2010/11 by encouraging our staff to work in different ways in order to deliver greater efficiency and productivity without compromising quality.

We have also implemented an organisational restructure which has established three clinical divisions, each with a Divisional Medical Director and a Divisional Director of Operations, to enhance clinical leadership in the Trust.

We believe the Trust is well placed to face the tough challenges of the years ahead and develop its reputation as a hospital of choice.

Performance against corporate objectives 2009/10

Corporate Objective 1: Improve patient safety and clinical effectiveness

- We were rated as the fourth best performing hospital in England for patient safety in the Dr Foster Hospital Guide 2009
- We were rated 'Excellent' for 'Quality of Services' in the NHS annual performance ratings 2009
- We met a national target to treat 95% of outpatients and 90% of inpatients within 18 weeks of GP referral and we also met a national target to treat 98% of A&E patients within four hours
- We met targets for the reduction of MRSA bacteraemia and Clostridium difficile—10 cases of MRSA (against a target of 19 cases set by the Care Quality Commission) and 32 cases of *C. difficile* (against a target of 109 cases set by the Care Quality Commission)
- We achieved NHS Litigation Authority risk management standards for Maternity at Level 2

Corporate Objective 2: Improve the patient experience

- 90% of patients in the annual NHS inpatient survey 2009 rated their care as 'Excellent', 'Very good' or 'Good'
- We demonstrated a progressive improvement in key issues identified by the annual NHS inpatient survey 2009, performing significantly better on 16 questions compared with the 2008 survey and significantly worse on no questions
- We implemented the use of a 'real-time' electronic patient feedback tool, the Patient Experience Tracker (PET), and by the end of 2009/10 76% of patients on inpatient wards were giving their views on their care using the PET
- We rolled out the *Releasing Time to Care—The Productive Ward* programme to 14 wards in 2009/10 to improve ward processes and environments so that staff are able to spend more time caring directly for patients
- Administrative processes have been improved by centralising most medical secretaries and all appointment bookings and admissions staff in a new purpose-built area of the hospital—this has led to a significant reduction in patient complaints relating to appointments and admissions
- 65% of staff took part in the annual NHS staff survey 2009 (compared with 61% in 2008 and 53% in 2007)—we improved or maintained our performance for 83% of the survey's 36 key findings

Corporate Objective 3: Deliver excellence in teaching and research

- We led a successful bid to establish and host the North West London Health Innovation and Education Cluster (HIEC) which aims to ensure that patients receive better treatment as a result of promoting innovation, quality and productivity through training and education of healthcare staff
- We continued to participate actively in the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Northwest London which is hosted at Chelsea and Westminster
- The Trust developed its Research Strategy which is due to be approved and implemented in 2010/11

Corporate objectives 2010/11

Corporate Objective 1: Improve patient safety and clinical effectiveness

Patient safety

- Reduce hospital acquired preventable venous thromboembolism (VTE) by 20%
- Reduce the incidence of falls resulting in moderate or major harm by at least 25%
- Ensure that no elective patient is infected with MRSA bacteraemia while in the hospital

Clinical effectiveness

- Meet agreed targets based on National Confidential Enquiry into Patient Outcome & Death (NCEPOD) recommendations for emergency surgery
- Reduce the Trust's Hospital Standardised Mortality Ratio (HSMR) by 5%
- Be at or below the national average of patients with an indwelling urinary catheter and reduce the number of urinary catheter days, excluding patients who need a lifelong urinary catheter

Corporate Objective 2: Improve the patient experience

- Achieve performance above the national average on five selected questions in the 2010 NHS inpatient survey in order to be more responsive to the personal needs of patients
- Improve the patient experience for women and children by:
    - Achieving a 90% satisfaction score for patient experience on the postnatal ward, as measured by the Patient Experience Tracker (PET)
    - Reducing the waiting time for an appointment in the antenatal clinic to no longer than 15 minutes
    - Achieving a 90% satisfaction score for patient experience in children's outpatients, as measured by the PET
- Reduce the number of complaints relating to appointments and admissions by 30%
- Increase staff satisfaction by achieving the upper quartile scores for appraisals and Personal Development Plans (PDPs) in the national staff survey and make a year-on-year improvement in sickness absence rates, vacancy rates and uptake of mandatory training

Corporate Objective 3: Deliver excellence in teaching and research

- Deliver an agreed improvement in students' overall rating of their teaching
- Implement the Research Strategy including the CLAHRC programme
- Achieve Year One priorities for the Health Innovation Education Cluster (HIEC)

Corporate Objective 4: Ensure financial and environment sustainability

- Deliver the financial plan for 2010/11
- Improve performance on environmental sustainability by:
    - Completing a programme to install automatic meter reading for gas and electricity usage
    - Improving our overall rating for the Corporate Good Citizen Assessment model with the intention of achieving at least the London average by March 2011
    - Increasing recycling rates in 2010/11 from their current level of 29% to 40% of all waste

The Trust has agreed targets for emergency surgery

Quality Report

The Trust achieved NHS Litigation Authority risk management standards for Maternity at Level 2 following an assessment visit in February 2010

Statement on quality from the Chief Executive

The Trust Board of Directors is committed to providing high quality care for our patients.

This commitment to meeting the challenge of delivering quality and efficiency underpins our corporate objectives for 2010/11:

- Improve patient safety and clinical effectiveness
- Improve the patient experience
- Deliver excellence in teaching and research
- Ensure financial and environmental sustainability

This Quality Report is as important as the Finance section of the Annual Report & Accounts.

I am very grateful to our stakeholders for contributing to the development of this Quality Report, in particular our staff and Governors, to ensure that we are reflecting and addressing the concerns that matter to patients and the public.

Our longstanding focus on quality improvement has ensured that we have set high standards for quality:

- The Trust was registered without conditions by the Care Quality Commission (CQC) from 1 April 2010 when a new system for regulating standards in the NHS became law—to be registered, the Trust needed to show it could meet new essential standards of quality and safety which the CQC will monitor

- Chelsea and Westminster was named as one of the best hospitals in the country for patient safety by the Dr Foster Hospital Guide in November 2009—Chelsea and Westminster was fourth best in England and the best performing hospital in North West London

- The Trust achieved NHS Litigation Authority risk management standards for Maternity at Level 2 following an assessment visit in February 2010—we were already at Level 2 for the general Trustwide standards

- We significantly outperformed national targets for the reduction of both MRSA bacteraemia and *Clostridium difficile* in 2009/10

- Chelsea and Westminster was given a clean bill of health by the CQC following an unannounced inspection in May 2009 to assess whether the Trust adequately protects patients, staff and visitors from infection

We are proud of these achievements and we are committed to improving quality further—our performance against our priorities for quality improvement in 2009/10 and the priorities for quality improvement that we have set for 2010/11 are outlined in this Quality Report.

The Board of Directors is committed to maintaining and improving quality and the Trust is in a strong position to rise to this challenge in partnership with staff, patients and other stakeholders.

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

Heather Lawrence

Heather Lawrence OBE
Chief Executive

Priorities for quality improvement 2010/11

Following consultation with key stakeholders the Trust Board of Directors has agreed the following priorities for quality improvement in 2010/11:

Priority 1: Patient safety

To reduce hospital acquired preventable venous thromboembolism (VTE) by 20%

Why is this a priority?

Deep vein thrombosis (DVT) is a common medical condition that occurs when a blood clot forms in a deep vein, usually in the leg or the pelvis. A DVT can block off or reduce the flow of blood in the vein. Sometimes it breaks off and travels to the arteries of the lung where it will cause a pulmonary embolism (PE). DVT and PE are known collectively as venous thromboembolism (VTE).

PE is a major cause of preventable death and a DVT may result in lifelong disability with painful leg swelling, varicose veins and leg ulcers. Reducing the incidence of VTE is a national priority for the NHS.

Approximately half of all cases of VTE occur in patients who have had a recent stay in hospital. VTE is one of the most common preventable causes of hospital deaths. It is estimated that in England each year more than 25,000 people die from preventable VTE contracted in hospital.

About one third of patients will develop VTE despite the best care but we can help prevent VTE occurring in two thirds of patients by providing appropriate preventative treatment.

What did we do in 2009/10?

The Trust has established a multi-disciplinary committee to tackle this priority. We have introduced a number of measures to raise awareness among patients and staff to ensure that all patients admitted to hospital are assessed for their risk of VTE and treated appropriately:

- We have published a patient information leaflet on DVT and PE and a pocket guide for staff which includes guidance on assessing risk factors for VTE and treatment to prevent VTE in at-risk patients

- We have designed an electronic VTE risk assessment for use with adult inpatients which highlights what preventative treatment may be required, supported by an electronic prescribing alert which appears if an at-risk patient has not been prescribed preventative anticoagulant drugs

How did we perform in 2009/10?

We set ourselves an initial target in 2009/10 to reduce preventable VTE by 15%. We wanted to measure the number of DVTs and PEs diagnosed at this hospital that occurred during an admission or within three months of an admission in order to establish a baseline.

Nationally it is recognised that data accuracy for VTE is a problem and so an audit was undertaken to assess the accuracy of the reported data for a four-month period from 1 September to 31 December 2009.

We identified 58 patients who were coded as having had a VTE of whom nine had been coded incorrectly—they did not have a VTE although it was considered as a possible diagnosis. Of the 49 patients who did have a VTE, 12 had a recent admission to Chelsea and Westminster Hospital and three had a recent admission to another hospital. The remaining 34 patients had a VTE unrelated to a hospital admission. Now that we have established an approximate number of cases for a four-month period, we can measure progress towards our target and have decided to increase it to a 20% reduction in 2010/11.

We have undertaken audits on the wards to establish the number of patients who receive appropriate anticoagulant drugs to prevent DVT and PE. An audit on an orthopaedic ward in 2008 showed that only 32% of patients were receiving appropriate preventative anticoagulant drugs despite the introduction of electronic prescribing pop-up alerts reminding doctors to prescribe the drugs, if they had not already been prescribed.

However, this figure rose to 69% in 2009 following the introduction of revised guidelines and clearer wording in the pop-up alerts. An audit of patients undergoing planned hip and knee replacement surgery performed for two weeks in March 2010 showed that 83% of patients were offered an information leaflet on DVT and PE at the pre-assessment clinic and 83% of patients were wearing stockings to prevent DVT.

What actions are we planning to improve our performance?

We are changing the VTE risk assessment in line with the new Department of Health VTE risk assessment tool. We will extend the risk assessment to include maternity and day case patients as well as all inpatients. We plan to make the risk assessment mandatory to ensure that all patients will be risk assessed. We will undertake a root cause analysis of all cases of DVT and PE occurring during a hospital admission or within three months of admission. This will help us identify areas where we can make improvements to prevent VTE in other patients.

How will improvement be measured and monitored?

We will monitor cases of preventable VTE bi-monthly and rates of VTE risk assessment completion for all adult patients monthly. We will audit on a regular basis whether appropriate preventative treatment is being provided Trustwide.

How will progress be reported?

Progress will be reported at the multi-disciplinary Thrombosis and Thromboprophylaxis Committee every two months and at the Quality Committee and the Assurance Committee on a quarterly basis.

Priority 2: Patient experience

To achieve a progressive improvement in issues identified in the annual national inpatient survey relating to communication, information and responsiveness to the personal needs of patients

Why is this a priority?

Improving the patient experience is a key Trust corporate objective and issues relating to communication and information have been highlighted as areas for improvement in the Trust's national inpatient survey results.

In addition, there is a national focus in 2010/11 on responsiveness to the personal needs of patients.

What did we do in 2009/10?

We used a 'real-time' electronic patient feedback tool called the Patient Experience Tracker (PET) to ask five questions relating to the inpatient survey questions we wished to address:

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 the ward?

A total of 13 inpatient adult wards, including the postnatal ward, have been using the PET since June 2009 and this was extended to other clinical areas during 2009/10.

How did we perform in 2009/10?

Obtaining sufficient responses from patients to ensure the validity of the PET results has been a key challenge since its introduction in the Trust. However, by March 2010 the Trust achieved a 76% response rate for inpatient ward areas.

Overall in 2009/10 patients using the PET reported a satisfaction score of 86% against a target score of 90%.

National inpatient survey results

The PET questions relate to the inpatient survey questions as shown in the table below which also compares the Trust's performance in the 2008 and 2009 surveys and the national average for 2009.

The results are expressed as problem scores—a low score is a good score. Different questions have different responses and the problem score combines these categories. A problem score shows the percentage of patients for each question who, by their response, indicated that a particular aspect of their care could have been improved.

PET question reference	Inpatient survey reference	Inpatient survey question	2008	2009	National average 2009
1	E3	How much information about your condition or treatment was given to you?	18%	**18%**	21%
2	E2	Were you involved as much as you wanted to be in decisions about your care and treatment?	49%	**40%***	46%
3	C1+	When you had important questions to ask a doctor, did you get answers you could understand?	29%	**23%***	31%
	D1+	When you had important questions to ask a nurse did you get answers that you could understand?	45%	**38%**	35%
4	C3	Did doctors talk in front of you as if you were not there?	29%	**24%**	27%
	D3	Did nurses talk in front of you as if you were not there?	33%	**25%**	23%
5	H3	Overall, how would you rate the care you received?	6%	**5%***	7%
	H6	During your hospital stay, were you ever asked to give your views on the quality of your care?	77%	**75%**	79%

The Trust has improved its performance against all of the above questions when comparing the 2009 and 2008 survey results, except E3 for which performance remained the same as the 2008 survey. The Trust performed significantly better than the national average in the 2009 survey for those questions marked with (*).

What are our objectives in 2010/11?

This year we will continue our work on information and communication but will focus on improving responsiveness to the personal needs of patients. Our target is to be above the national average on five questions from the inpatient survey as outlined in the table below. This indicates how the Trust currently compares to the national average as well as a historical comparison—a low score is a good score.

Inpatient survey reference	Inpatient survey question	2008	2009	National average 2009
E2	Were you involved as you wanted to be in decisions about your care and treatment?	49%	**40%***	46%
E5	Did you find someone to talk to about your worries and concerns?	60%	**59%**	57%
E6	Were you given enough privacy when discussing your condition or treatment?	32%	**27%***	29%
G7	We you told about medication side effects to watch out for when you went home?	46%	**48%**	47%
G12	Were you told who to contact if you were worried about your condition after you left hospital?	24%	**24%**	22%

The Trust performed significantly better than the national average in the 2009 survey for those questions marked with (*).

What actions are we planning to improve our performance?

We will work with our staff and other Foundation Trust members through our Council of Governors to identify how we can improve the experience of patients in these five areas.

We will also look at our patient feedback from surveys, comment cards and complaints. We will develop further our information campaign for staff and patients telling people what we are doing in each area and what patients should expect.

How will improvement be measured and monitored?

We will judge our success by what our patients tell us in the annual national inpatient survey. We will also review how we are doing by regularly asking patients using our Patient Experience Tracker.

How will progress be reported?

Progress will continue to be reported quarterly through the Patient Experience Steering Group and will be overseen by the Assurance Committee, a sub-committee of the Board. The Council of Governors will also receive regular updates on progress in understanding and responding to patients' experience.

Improving the patient experience in Maternity and Children's & Young People's Services

In addition to the general Trustwide objective to improve the patient experience, the Trust also had a specific objective to improve the patient experience for women using our maternity services and for children and young people.

Maternity

We set ourselves a priority in 2009/10 of specifically improving women's experience of our maternity services to contribute to our overall strategy of being a centre of excellence in women's and children's health.

Our Maternity Unit was chosen as a pilot site in 2008/09 for a patient experience project run by Monitor, the independent regulator of Foundation Trusts, and McKinsey, an external management consultancy, to help better understand and action patients' concerns.

Senior clinical staff, community representatives, Governors and managers worked in small groups to drive forward this work. The themes for improvement that were identified and the actions that we have taken are as follows:

Communication with patients
We have improved our maternity services website and reviewed most of the patient information leaflets. We have recruited midwifery matrons who visit the wards and clinics daily and pick up any concerns there and then. In addition, the senior midwife on Labour Ward now speaks to every woman after she has had her baby to answer any questions or concerns immediately.

Women using our maternity services told us that they found it difficult to identify different staff groups and so we have introduced new uniforms, using different colours for different staff groups with their relevant designation (eg midwife, doctor) embroidered on the front.

Environment for staff and patients
We have improved the 24-hour cleaning on Labour Ward, replaced all Labour Ward beds, and the refurbishment and redecoration of all bathrooms is due to start shortly. In addition, the refurbishment of the Antenatal Clinic is due to start in summer 2010.

Staffing
In April 2009 the midwifery establishment was increased by 15%. A successful recruitment strategy was implemented and this has meant that the use of agency staff has decreased significantly over the course of the year and is now rarely required. In order to support further the service and staff,

all senior managers (midwives) are now on a rota to work a percentage of their time on the wards in clinical practice.

1:1 care in labour
We know that it is important to women that they have 1:1 care during their labour (where care is received from a designated midwife throughout labour) and we have made excellent progress in implementing this, with daily audits demonstrating 100% compliance over the past year.

Patient Experience Tracker (PET)

The Patient Experience Tracker (PET) has been used on the postnatal ward since June 2009 and in the Antenatal Clinic since January 2010.

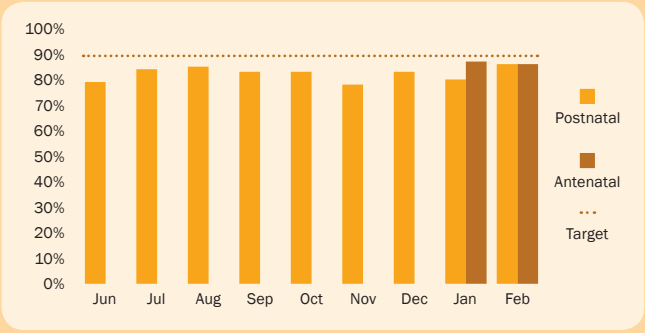
The patient experience project run by Monitor and McKinsey highlighted the areas we wished to measure and specific questions were devised as follows:

Postnatal ward
- Did you get information you could understand?
- Did you feel the ward was clean enough?
- Were the staff kind and caring?
- Did you feel welcomed when you arrived?
- Overall how would you rate your experience on this ward?

Antenatal Clinic
- How would you rate the level of waiting time for your appointment today?
- Were staff friendly and approachable?
- How would you rate the process of booking your appointment?
- Were you satisfied with the information supplied about your schedule of care?
- Overall how would you rate your care on the unit?

How did we perform in 2009/10?

Maternity Services satisfaction
Jun 2009–Feb 2010



The postnatal ward reported an overall patient satisfaction score of 82% and the Antenatal Clinic reported an overall satisfaction score of 85%. The target score for both areas was 90%.

The area of most dissatisfaction in the Antenatal Clinic was appointment waiting time.

Children's and Young People's Services

In January 2010 we introduced the PET into our Children's and Young People's Services—in Children's Outpatients.

The overall satisfaction score in Children's Outpatients was 74% but this masks variable performance, for example the satisfaction score for waiting times during the child's appointment was only 56% and the satisfaction score for the process of booking an appointment was 71%.

However, the satisfaction score for information giving was 82% and the satisfaction score for staff being friendly and approachable was 86%.

What are our objectives in 2010/11 for Maternity and Children's and Young People's Services?

- To achieve a 90% satisfaction score for patient experience on the postnatal ward, as measured by the PET
- To reduce the waiting time for an appointment in the Antenatal Clinic to no longer than 15 minutes
- To achieve a 90% satisfaction score for patient experience in Children's Outpatients, as measured by the PET

What actions are we planning to improve our performance?

While our performance on the postnatal ward, as measured by the PET, has improved, it is a slight increase and our focus this year will be on understanding more about the areas of concern through engagement with users of the service in order to make a more substantial improvement.

The Trust Board approved capital to improve the Antenatal Clinic environment, taking into account ways to improve the patient journey to make it more efficient and reduce waiting times. For example, we will introduce touch screens for patients to check in.

The refurbishment is due to take place in late summer 2010.

In Children's Outpatients, we will implement the improvement plan which includes increasing consultation time and space, revising the booking policy and improving communication about delays.

How will improvement be measured and monitored?

We will use the PET to monitor progress on patient satisfaction in each area.

How will progress be reported?

Progress will be reported quarterly through the Maternity Services Management Board, Children's Services Management Board and the Patient Experience Steering Group, and will be overseen by the Assurance Committee, a sub-committee of the Board.

The Council of Governors will also receive regular updates on progress in understanding and responding to patients' experience.

Priority 3: Clinical effectiveness
To meet agreed targets based on National Confidential Enquiry into Patient Outcome & Death (NCEPOD) recommendations for emergency surgery

Our target in 2009/10 was to reduce delays of more than 24 hours to selected non-elective urgent surgery. We needed to define delays and introduced new measurements as described below. This has enabled us to be more specific about what we are trying to achieve.

Why is this a priority?

Senior surgeons had expressed concerns about delays for some patients needing urgent surgery. No empirical measures or data were available to use as a baseline but there was significant anecdotal evidence that some patients were experiencing delays to emergency surgery.

What did we do in 2009/10?

Typically a patient needing acute surgery is admitted to a ward by the responsible surgical team. Once a decision to operate is made, the surgical team books the patient on the emergency operating list. The period we are measuring is the time from booking to the anaesthetic start time.

We adopted the NCEPOD classification of surgical priority which outlines four levels of surgery:

- **Immediate**—immediate life, limb or organ saving intervention
- **Urgent**—normally within hours of decision to operate
- **Expedited**—normally within days of decision to operate
- **Elective**—routine admission for planned surgery at a time convenient for the patient

The first three levels apply to emergency surgical cases. However, by definition the first level always has almost instant access to theatre and so we decided to focus on urgent and expedited cases. The times for these categories were not defined and so the Trust adopted the following definition:

- **Urgent**—within 24 hours of booking
- **Expedited**—within 4 working days of booking

The information to measure our performance was either not available or incomplete on the electronic theatre booking system and so a paper-based method had to be implemented. We will include routine measurement as part of the implementation of the new electronic theatre booking system which is due to take place in September 2010.

We designated one of the theatres as the emergency theatre to increase the capacity for emergency surgery and introduced a daily review of the waiting emergency cases by the anaesthetists and surgical specialties to agree priorities.

How did we perform in 2009/10?

The problems with data collection meant that we were unable to collect data until December 2009 and so our results are a reflection of the work undertaken so far.

Performance against standards for emergency surgery 1–7 December 2009

Classification	N° of cases	Outcomes	% achieving target
Immediate	3	All 3 to theatre immediately	**100%**
Urgent	27	26 within 24 hours,1 in 26 hours	**96%**
Expedited	24	22 within 4 days, 2 within 7 days	**91%**
Total	**54**		**94%**

Performance against standards for emergency surgery 1–7 March 2010

Classification	N° of cases	Outcomes	% achieving target
Immediate	3	All 3 to theatre immediately	**100%**
Urgent	46	42 within 24 hours, 3 in 36 hours, 1 case 55 hours (delay with Imaging)	**91%**
Expedited	20	19 within 4 days, 1 within 7 days	**95%**
Total	**69**		**93%**

What actions are we planning to improve our performance?

We wish to continue to focus on this target so that the initiatives become fully embedded and we can be assured through better data collection that we are meeting the targets we have set. The planned upgrade to the electronic theatre booking system will help achieve this.

We also wish to look in more detail at particular diagnoses, for example time to surgery for patients with fractured neck of femur.

How will improvement be measured and monitored?

Improvement will be measured as it is currently until the electronic theatre booking system is functioning when data collection will be much easier. Performance will be monitored through the Theatre Emergency Group.

How will progress be reported?

Progress will be reported to the Quality Committee and the Assurance Committee on a quarterly basis.

Priority 4: Patient Safety
To reduce the incidence of falls resulting in moderate or major harm by at least 25% in 2010/11

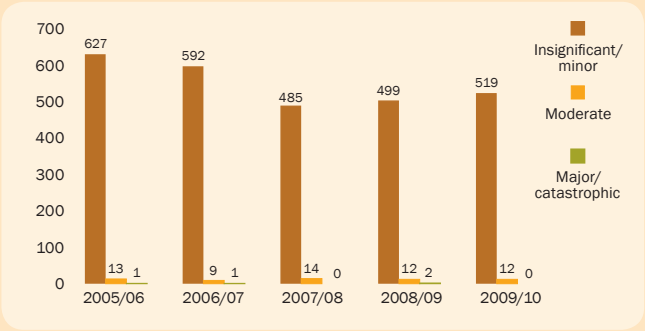
Why is this a priority?

Nationally falls are the most reported safety incident and are consistently among the Trust's top three most reported incidents. Approximately 10–30% of falls result in harm to the patient, of which 10% of injuries are moderate or serious.

We know from feedback and complaints how a fall can cause distress to a patient and their family and can lead to a longer stay in hospital than expected. We have therefore decided to add this to our priorities for quality improvement in 2010/11.

How did we perform in 2009/10?

Patient falls per year, 2005–10



What actions are we planning to improve our performance?

We already have a Falls Group and we plan to strengthen this by having more senior clinical membership and changing the reporting lines to give the Group a higher profile.

The Group will adopt the Patient Safety First campaign interventions. These include a wide range of measures such as identifying training requirements, developing and implementing a plan for falls prevention training, and instigating a rolling programme of environmental risk assessments.

We will also focus on achieving consistent and good quality reporting.

In addition, a standing panel for the investigation of falls will be established which will allow consistency in investigation and ensure that learning is embedded. A patient Governor will be invited to be part of this panel.

We are grateful to the Friends of Chelsea and Westminster Hospital for supporting our pilot of falls alarms on our medical wards which will be rolled out to other areas if successful.

This alarm indicates when 'at risk' patients are moving (eg standing up) and will allow prompt help to be provided.

How will improvement be measured and monitored?

Improvement will be measured and monitored through the current incident reporting system and through indicators to be developed by the Falls Group.

How will progress be reported?

Progress will be reported to the Quality Committee and the Assurance Committee on a quarterly basis.

Statements relating to quality of NHS services provided

Statements of assurance from the Trust Board

During 2009/10 Chelsea and Westminster Hospital NHS Foundation Trust provided and/or sub-contracted 54 NHS services.

The Trust has reviewed all the data available to us on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2009/10 represents 100% of the total income generated from the provision of NHS services by the Trust in 2009/10.

Review of data on quality of care

The Trust has systems and processes in place to review data on quality regularly. Directorate specific quarterly clinical governance reports are provided which cover a wide range of data including complaints, concerns, claims and incidents. Incident trends and the outcomes of more serious incident investigations are reviewed to ensure that actions are followed through and changes implemented.

The reports also include risks on the risk register and progress on actions, data on the incidence of MRSA and *C. difficile*, the results of monthly hand hygiene audits, progress on updating clinical guidelines, progress on clinical audits, legal claims and research activity. The results of Trustwide audits in areas including documentation and consent are reported at directorate level.

Patient experience is addressed through reviewing complaints and concerns as well as progress on completion rates and satisfaction scores from the Patient Experience Tracker (PET), and national inpatient survey results.

Problems identified using this data are addressed at local level through the directorate management systems or, if appropriate, escalated to the Executive team. All the data available at local level is also monitored at corporate level through the Trust Executive for Clinical Governance. An internal audit on the use and value of the quarterly clinical governance reports is in progress to provide assurance on this element of our quality system.

The Trust Executive has the responsibility to drive up quality. Additional challenge and scrutiny is provided by the Assurance Committee which is a sub-committee of the Board. The annual business planning process seeks to involve staff at all levels in the organisation to identify issues to be addressed. A number of key areas for improvement have been identified by this process and are included in our quality improvement plan for 2010/11.

We have also undertaken an in-depth review of some of our services. Paediatric high dependency care and paediatric surgery were reviewed as part of our successful bid for designation as a hub for paediatric and neonatal surgery in North West London. We assessed ourselves against the Royal College of Paediatrics and Child Health and other national standards as part of this process and this led to changes in our proposed service including strengthening the staffing for the Paediatric High Dependency Unit.

As part of the bid for Stroke Unit designation we reviewed our services against national guidelines and Healthcare for London quality standards. We were subsequently accredited for providing the required levels of care. We also reviewed our maternity services in detail, partly in response to a Healthcare Commission review and partly in response to concerns raised by patients through complaints. We are currently undertaking a review of the medicine directorate.

A quality improvement plan has been agreed by the Board. This includes a commitment to undertake more in-depth reviews, a focus on clinical audit as a tool for improvement and assurance, the development of a Board dashboard to include our quality indicators, work on further indicators, and further development of our engagement and feedback processes.

Participation in clinical audits

During 2009/10, 29 national clinical audits and eight national confidential enquiries covered NHS services that the Trust provides. During 2009/10 the Trust participated in 83% of national clinical audits and 87% of national confidential enquiries that it was eligible to participate in.

See below for full details including:

- National clinical audits and national confidential enquiries that the Trust was eligible to participate in
- National clinical audits and national confidential enquiries that the Trust participated in and for which data collection was completed
- Number of cases submitted to each audit or enquiry as a percentage of the number of registered cases indicated/ required by the terms of that audit or enquiry

National Clinical Audits—Continuous (with no planned end date)

Topic	Eligible to participate	Participated	Cases indicated/ required	Cases submitted	% cases submitted
NNAP: Neonatal Care	Yes	Yes	574	574	100
NDA: National Diabetes Audit	Yes	Yes	41	41	100
ICNARC CMPD: Adult Critical Care Units	Yes	No			
National Elective Surgery PROMs: Hip Replacements*	Yes	Yes	111	10	9
National Elective Surgery PROMs: Knee Replacements*	Yes	Yes	163	18	11
National Elective Surgery PROMs: Varicose Veins*	Yes	Yes	131	23	18
National Elective Surgery PROMs: Hernia*	Yes	Yes	378	41	10
CEMACH: Perinatal Mortality 2009: Neonatal Deaths	Yes	Yes	20	20	100
CEMACH: Perinatal Mortality 2009: Stillbirths	Yes	Yes	28	28	100
NJR: Hip and knee replacements	Yes	Yes	239	239	100
NLCA: Lung Cancer	Yes	Yes	53	52	98
NBOCAP: Bowel Cancer	Yes	Yes	62	88	100
MINAP (including ambulance care): AMI & other ACS	Yes	Yes	20	20	100
Heart Failure Audit	Yes	Yes	143	10	7
NHFD: Hip Fracture	Yes	Yes	60	48	80
TARN: Severe Trauma	Yes	Yes	5	5	100
NHS Blood & Transplant: Potential Donor Audit	Yes	No			

*Note: PROMs data is for period up to December 2009

National Clinical Audits—Intermittent (samples recruited according to time period or sample size; one-off, with no plan to repeat patient recruitment in the future)

Topic	Eligible to participate	Participated	Cases indicated/ required	Cases submitted	% cases submitted
National Sentinel Stroke Audit	Yes	Yes	20	26	100
National Audit of Dementia	Yes	Yes	40	Data entry to 16 Jul 2010	n/a (ongoing study)
National Falls & Bone Health Audit	Yes	Yes	60	60	100
National Comparative Audit of Blood Transfusion	Yes	Yes	40	27	68
National Comparative Bedside Transfusion Audit	Yes	Yes	40	27	68
British Thoracic Society: Respiratory Diseases—Adult Community Acquired Pneumonia, NIV (Adult), Paediatric Pneumonia	Yes	No			
College of Emergency Medicine: Asthma	Yes	Yes	50	41	82
College of Emergency Medicine: Fractured NOF	Yes	Yes	50	39	78
College of Emergency Medicine: Pain in children	Yes	No			
College of Emergency Medicine: Pain in children	Yes	No			

National Clinical Audits—One-Off (all patients)

Topic	Eligible to participate	Participated	Cases indicated/ required	Cases submitted	% cases submitted
National Mastectomy & Breast Reconstruction Audit	Yes	Yes	3	3	100
National Oesophago-Gastric Cancer audit	Yes	Yes	33	33	100
RCP Continence Care Audit	Yes	No			

National Confidential Enquiries

Topic	Eligible to participate	Participated	Cases indicated/ required	Cases submitted	% cases submitted
NCEPOD: Peri Operative Care	Yes	Yes	Prospective data collection so n° of cases unknown	Data collection from Mar 2010 to Mar 2011	n/a—ongoing study
NCEPOD: Surgery in Children	Yes	Yes	48	Data collection ongoing until end of Jun 2010	Not available currently
NCEPOD: Emergency Elective Surgery in the Elderly	Yes	Yes	8	8	100
NCEPOD: Cosmetic Surgery	Yes	Yes	None that met criteria during study period	n/a	n/a
NCEPOD: Parenteral Nutrition	Yes	No	Did not participate	0	0
CEMACE: Maternal and Perinatal Surveillance	Yes	Yes	48	48	100
CEMACE: Obesity in Pregnancy	Yes	Yes	Prospective data collection so n° of cases unknown	Data entry to 2011	n/a—ongoing study
CEMACE: Head Injury in Children	Yes	Yes	32	20	63

The reports of 11 national clinical audits were reviewed by the Trust in 2009/10. See below for details of actions that we intend to take to improve the quality of care.

National audit	Actions to be taken
NNAP: Neonatal Care	No actions required—Trust standards exceed National Comparators.
CEMACH: Perinatal Mortality 2009: Neonatal Deaths	No actions required—Trust standards exceed National Comparators.
CEMACH: Perinatal Mortality 2009: Stillbirths	No actions required—Trust standards exceed National Comparators.
NLCA: Lung Cancer	To improve data completeness by submitting data prospectively and using the cancer waiting times database.
NBOCAP: Bowel Cancer	Data within the National Audit report conflicts with annual local service review, therefore to focus on the improvement of information submission for staging of disease.
Heart Failure Audit	Further develop inpatient services for heart failure through the use of an Integrated Care Pathway.
National Sentinel Stroke Audit	No actions required—Trust standards exceed National Comparators.
National Comparative Audit of Blood Transfusion	No action required—Trust standards exceed National Comparators.
National Comparative Bedside Transfusion Audit	No action required—Trust standards exceed National Comparators.
College of Emergency Medicine: Asthma	A review of the audit report findings and proposed action plan will be presented at the clinical governance half day in June 2010.
College of Emergency Medicine: Fractured NOF	To introduce fast tracking of patients to the ward. To improve speed of pain relief. Each patient is pain assessed (reflected on the casualty card) and the optimum time period is pain relief within 20 minutes of arrival.

The reports of 74 local clinical audits were reviewed by the Trust in 2009/10 and we intend to take actions to improve the quality of care. Details are available on request from Dr Mike Anderson, Trust Medical Director at mike.anderson@chelwest.nhs.uk.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Chelsea and Westminster Hospital NHS Foundation Trust in 2009/10 who were recruited during that period to participate in research approved by a research ethics committee was 3,000.

In 2009/10 the Trust was involved in conducting 121 multi-disciplinary clinical research studies, 16 of which were supported by the National Institute of Health Research (NIHR) and its research networks.

During 2009/10 there was a 27% increase in patient recruitment into NIHR studies compared with 2008/09. This increasing level of participation in clinical research demonstrates our commitment to increase patient access to high quality research.

In the last three years, 600 publications have resulted from our involvement in research, helping to improve patient outcomes and experience across the NHS.

Of the 121 studies given permission to start in 2009/10, 50% were given permission by an authorised person less than 30 days from receipt of a valid complete application and 80% of these studies were established and managed under national model agreements outlined by the Department of Health.

Goals agreed with commissioners

A proportion of Trust income in 2009/10 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2009/10 and for the following 12-month periods are available from the Foundation Trust Secretary at ftsecretary@chelwest.nhs.uk.

In 2009/10, 0.5% of our main acute contract income, which covers most of our NHS services, was conditional upon achieving CQUIN goals agreed with our host commissioner, NHS Kensington and Chelsea. We also agreed CQUIN payments linked to our more specialist work in HIV and Neonatal Intensive Care, which are commissioned by specialist commissioners, and for our community services in Paediatrics, Dermatology and Gynaecology.

We achieved 93% of our CQUIN-related goals in 2009/10 and will therefore receive a payment of £1.35m linked to these achievements, compared with a maximum payment of £1.45m. The breakdown of our payments by contract is as follows:

Contract	Value (£000)
Main acute contract	1,120.8
HIV specialist contract	204.5
Neonatal Intensive Care specialist contract	23.3
Total	**1,348.6**

The unachieved CQUIN of £0.1m relates to missed stretch targets on MRSA bacteraemia, *C. difficile* and prescribing performance for anti-microbials prescribed on discharge. We agreed and delivered on a wide range of quality indicators to underpin these payments—a few examples of CQUIN-related goals are listed below:

Area of improvement	Indicator chosen	Rationale for inclusion
Patient Safety	Zero Elective MRSA Bacteraemia	MRSA bloodstream infections can be a major complication of surgery. Although the Trust strives to avoid all MRSA bacteraemia and has reduced its rate of MRSA by 90% in the last five years, there are still occasional situations where an infection does occur. However, with elective surgical cases, the Trust believes patients should expect to avoid hospital acquired infections and so we have agreed and achieved a target to have zero elective patients infected by MRSA bacteraemia.
Clinical Effectiveness	Patients' electronic discharge summary includes indication for treatment and intended duration of treatment for hospital initiated proton pump inhibitors therapy and for antimicrobials.	To enhance continuing care, where patients were being discharged with a course of treatment of either proton pump inhibitors or antimicrobials, the Trust agreed to ensure electronic discharge summaries provided GPs with information on how long patients should stay on these treatments and why the treatment was initiated. This information was agreed to be important to GPs in their ongoing care of patients after hospital discharge, including ensuring that patients did not stay on courses of treatment unnecessarily.
Patient Experience	Accelerated rollout of the Trust's Patient Experience Trackers (PETs)	The Trust introduced PETs in 2009/10 to enable the collation of 'realtime' patient feedback, which is in turn fed back to individual wards on a weekly basis. As a key part of the Trust's efforts to understand and improve on patients' hospital experience, we agreed a target with commissioners to ensure at least 40% of our patients were being surveyed by the end of 2009/10.
Enhanced Communications	Rollout of electronic discharge summaries to GP surgeries in neighbouring PCTs	The Trust had already successfully rolled out electronic discharge summaries to GP surgeries in NHS Kensington and Chelsea in 2008/09. The transfer of discharge information electronically sped up the process of getting information about discharged patients to their GPs and helps to reduce the unnecessary administrative costs of dealing with paper discharge summaries. This system has now been rolled out to GP surgeries in NHS Hammersmith and Fulham and NHS Westminster.

Statements from the Care Quality Commission

The Trust is required to register with the Care Quality Commission (CQC) and its current status is registration without conditions. We are not subject to periodic review by the CQC. The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Data quality

The Trust submitted records during 2009/10 to the Secondary Uses service for inclusion in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

- 90.8% for admitted patient care
- 73.6% for outpatient care
- 66.43% for Accident & Emergency (A&E) care

The percentage of records which included the patient's valid General Medical Practice Code was:

- 99.33% for admitted patient care
- 99.53% for outpatient care
- 100% for Accident & Emergency (A&E) care

Information Governance Toolkit attainment levels

The Trust's score for 2009/10 for Information Quality and Records Management, assessed using the Information Governance Toolkit, was 94.52%, exceeding our target of 90%.

Clinical coding error rate

The Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission. The error rate reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) was 7.3%—the national average is 9%.

The audit covered four areas—trauma and orthopaedics, general medicine, patients with a primary diagnosis affecting the nervous system, and cardiology (specifically arrhythmia or conduction disorders). The sample size was 300.

Due to the targeted nature of these audits and the small sample of activity audited it is not recommended that these results be extrapolated further than the actual sample audited.

Review of quality performance

How the Trust identifies local improvement priorities

The Trust is committed to understanding and responding to the patient experience and there are a number of ways in which we engage with our patients, staff and the public in determining priorities for quality.

As a Foundation Trust we have the benefit of a well-established and active Council of Governors which is an important source of views and experiences of people who use our services.

We seek clinicians' views through business planning sessions and Trust Executive for Clinical Governance meetings. We also have a number of mechanisms for more focused discussions. These include a maternity services steering group with patient and Governor representatives, which identified and then monitored the areas requiring improvement. As part of our plan to expand paediatric services we held a facilitated session which was attended by all grades of staff, patients and Governors to identify areas of concern and ideas for improvement.

There are also numerous patient forums in the Trust that represent specific areas including the Patient Environment Action Team, Maternity Services Liaison Committee and HIV Patient Forum. These forums influence how we design and deliver our services with an emphasis on quality.

To ensure we focus on equality and diversity we have developed a Single Equality Scheme in consultation with staff, patients and community groups. It identifies ways in which equality and diversity must be considered in the delivery of quality services. Our action plan includes improving the service that patients receive from the Appointments Office by, for example, printing letters in different languages or formats and using telephone translation services to communicate with patients who do not speak English.

The Trust has an Equality Impact Assessment toolkit, which is built into the Trust's business planning process, to ensure that equality and diversity issues are considered when making service changes.

There are two sub-committees of the Council of Governors that help to identify quality issues and prioritise and, in some cases, improve services. The Membership Sub-Committee focuses on not only increasing our membership but also engaging with and gaining feedback from our members. The Quality Sub-Committee has a specific remit to help identify priorities for quality and advise us on the content and focus of the Quality Report and quality improvement plan.

Staff Governors initiated a survey to ask staff and volunteers for their views on quality issues and what the Trust should be focusing on in 2010/11.

In order to help prioritise, the Trust identified areas in which we were aware of problems through complaints or incidents and areas in which there were evidence-based methods for improving care, and used these to discuss and agree priorities.

There was some consistency in issues raised. For example, the issues identified in the survey by Trust staff mirrored the key areas that the Governors had highlighted including discharge from hospital, waiting times for appointments, and falls. We have included reducing falls as an additional priority this year and will consider reviewing our indicators

and measurement for discharge in 2010/11 in conjunction with the Governors. The indicators selected for review outlined in the section below have been agreed as part of the engagement process.

The Trust is committed to working with Kensington and Chelsea Local Involvement Network (LINk) and this year we have embarked on a joint project looking at the nutritional and feeding support that patients receive in the hospital.

Performance indicators

Performance against local quality performance indicators 2009/10

The following table outlines performance against indicators for 2009/10 and includes new indicators selected by our stakeholders for monitoring in 2010/11.

Patient Safety	2008/09	2009/10	Target 2010/11	Comment
MRSA bacteraemia cases	5	10	3	
C. difficile cases	41	32	100	The nationally set target is 100 but we will aim for our local targets of 65 and 35, linked to financial incentives. We will aim towards the local targets but a more sensitive test for detecting *C. difficile* means that we will identify more cases.
Hand hygiene audit completion rates	57.7%	71%	90%	
Hand hygiene compliance rates	77%	80%	90%	
Patient falls resulting in moderate or major harm	14	12	9	This is one of our priorities for 2010/11. Data from local incident reporting system.
Incident reporting rate	6.6%	7.1%	8%	April to September data for 2008 and 2009 from the National Reporting and Learning System.
Never Events	0	0	0	Data from local incident reporting system.
% of observation charts completed accurately*	56.3	68 (Nov 2009)	80%	Local sampling audits. It is planned that this target will be increased further in 2011/2012.
Deaths from cardiac arrest*	23	12	12	This target refers to deaths where there is no return of spontaneous circulation.
% Patients with International Normalised Ratio (INR) less than 5*	No data	97.7% (Aug–Dec 2010)	At least 86%	Locally collected data. INR is a measure of the ability of the blood to clot.
Number of patients requiring opiate reversal*	No data	0% (1 week audit Aug 2009)	0%	Locally collected data. Plan to re-audit 1 week Aug 2010. Medication Safety Committee will monitor adverse events with opioids on an ongoing basis.
Ulcer prevalence (% of patients with pressure ulcers)	5.68	5.32	4	Measured by point prevalence.

Clinical Effectiveness	2008/09	2009/10	Target 2010/11	Comment
Mortality (HSMR)*	86.2	80.8	76.8	
% of patients with a catheter	28	17	12.5	Locally collected data.
Urinary catheter days*				Number of patient days that a catheter is in place (number of days multiplied by number of patients) excluding lifelong catheters—to be collected for 10/11. Local data.
% urgent surgery cases operated on within 24 hours of booking*		93.5% (Average of Dec 2009 and Mar 2009 data)	100%	Locally collected data.
% expedited surgery cases operated on within 4 days of booking*		93% (Average of Dec 2009 and Mar 2009 data)	100%	Locally collected data.

Patient Experience	2008/09	2009/10	Target 2010/11	Comment
PEAT scores	Excellent for food and the environment. Good for privacy and dignity	Excellent for food, the environment and privacy and dignity	Excellent for food, the environment and privacy and dignity	
Patient Experience Tracker completion rate*	n/a	75%	80%	See priority section. Locally collected data.
Patient Experience Tracker overall satisfaction scores*	n/a	85%	90%	See priority section. Locally collected data.
Complaints and concerns for admissions and appointments*	578	320	214	The target is a reduction of one third. Other indicators to be developed for measuring performance in this area this year—see corporate objectives.
Complaints responded to within target time (Formal complaints responded to in 25 working days)	92%	83%	90%	

*These indicators have been reviewed in detail this year, as part of our corporate quality objectives.

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

Performance against key national priorities 2009/10

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

Indicator Name	2009/10 Performance	Target
Incidence of *Clostridium difficile*	32	109
Incidence of MRSA Bacteraemia	10	19
18 Week Maximum Wait for Admitted Patients from Point of Referral to Treatment*	93.40%	90%
18 Week Maximum Wait for Non Admitted Patients from Point of Referral to Treatment*	98.97%	95%
Maximum time in A&E of 4 hours from arrival to admission, transfer or discharge	98.65%	98%
People suffering heart attack to receive Thrombolysis within 60 mins of call	n/a	n/a
All Cancer Two Week Wait**	96.63%	93%
Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)**	n/a	n/a
31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers**	98.51%	96%
31-Day Wait For Second Or Subsequent Treatment: Surgery**	98.13%	94%
31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments**	100.00%	98%
31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments**	n/a	94%
62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers**	93.01%	85%
62-Day Consultant Upgrade Wait For First Treatment: All Cancers**	100.00%	85%
62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers**	n/a	90%
Access to genito-urinary medicine clinics (48 hours)	100.00%	98%
Outpatients waiting longer than the 13 week standard	0.020%	0.03%
Inpatients waiting longer than the 26 week standard	0.028%	0.03%
Revascularisation waiting times (13 weeks)	n/a	n/a
Cancelled operations by the hospital for non-clinical reasons on the day of or after admission	0.52%	0.8%
Cancelled operations by the hospital for non-clinical reasons on the day of or after admission, who were treated within 28 days	4.52%	5%
Delayed transfers of care	1.20%	3.5%

* Predicted annual performance as published CQC performance is quarterly based only.

** Predicted annual performance as annual CQC performance will be published in June 2010.

Performance against Department of Health national core standards 2009/10

- Total number of Department of Health national core standards: **47**
- Total number of core standards against which the Trust declared itself as compliant to the Care Quality Commission: **47**

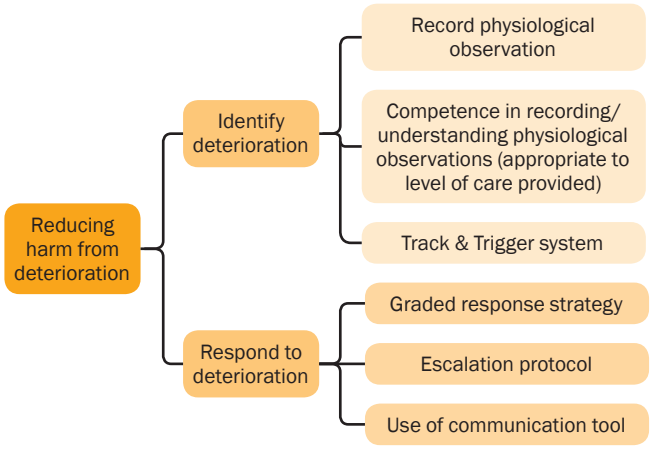
Progress on corporate quality objectives

In addition to our priorities for quality we set challenging corporate objectives for quality. Progress is described below.

Reduce in-hospital cardiac arrest and mortality through early recognition and treatment of the deteriorating patient

Ill patients can deteriorate while in hospital. It is important that this is recognised and appropriate, timely treatment is started. However, we also know from published evidence (www.patientsafetyfirst.nhs.uk) and our own experience that it does not always happen.

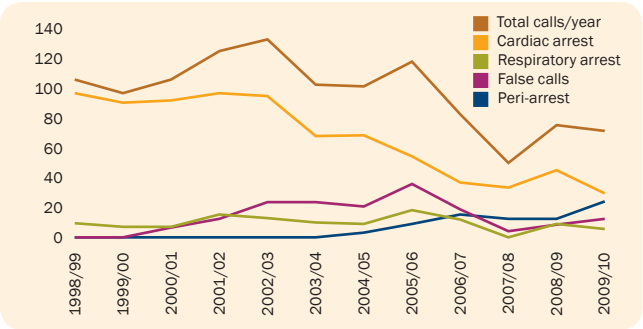
This indicator reflects the principles incorporated in the Patient Safety First (PSF) campaign intervention 'Reducing Harm from Deterioration' which can be summarised as follows:



Progress against this intervention in 2009/10 included:

- Improvement in the accuracy of completion of observations (heart rate, respiratory rate, blood pressure, temperature etc) from 56.3% in 2006 to 68% in 2009
- Introduction of a coloured observation chart in early 2010 to make it easier for staff to be alerted to changes in observations and potential deterioration (equivalent to the 'track and trigger' system in the PSF intervention)
- Reduction in resuscitation calls since 2003/04 as illustrated below
- Reduction in deaths at time of cardiac arrest from 23 deaths in 2008/9 to 12 deaths in 2009/10—these figures do not necessarily refer to survival but to patients who were resuscitated and had a pulse return at the time of resuscitation, as some of these patients would subsequently not survive

Resuscitation calls



In 2010/11 we plan to introduce a communication tool for all clinical staff and the Bedside Emergency Assessment Course for Healthcare Assistants (BEACH) course for support workers.

Reduce the risk of selected high risk medicines (warfarin and opioids) in line with measures recommended by the Patient Safety First campaign

Warfarin

Anticoagulants (including warfarin) are one of the classes of medicines most frequently identified as causing preventable harm to patients and admission of patients to hospital (National Patient Safety Agency—Patient Safety Alert 18—May 2007).

We carried out a one-week snapshot audit of all inpatients on warfarin in August 2009 to check the International Normalised Ratio (INR). This is a standard test that measures how long the blood takes to clot. It is important as it indicates whether warfarin is working properly. If it is too low there is a risk of blood clots and if it is too high (eg higher than five) there is a risk of serious bleeding. A performance standard of 95% was set for 2009/10 and the audit showed that 100% of inpatients had an INR of less than five during the one-week data collection period.

Guidelines for prescribing warfarin have been incorporated into the electronic prescribing system and systems put in place to ensure that reports of patients with INRs greater than five are regularly reviewed and individual patients followed up by the anticoagulant nurse. We also monitor adverse events related to anticoagulants on an ongoing basis and identify whether any further measures need to be implemented.

Opioids (including opiates and synthetic narcotics)

This group was chosen because of the frequency of involvement in reported incidents.

From April 2008 to March 2009, 701 incidents were documented on the Trust's Datix risk management database that involved a named medicine. Of these 701 incidents, the top 20 named medicines accounted for 140 incidents (20% of the total). Opioids accounted for 37 out of these 140 incidents (26%).

However, we found that during a one-week snapshot audit of all inpatients, no patient required reversal of opioid-related side effects with the reversal agent naloxone.

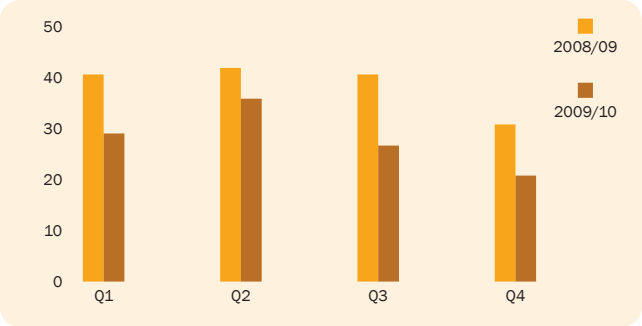
Reduce the number of complaints relating to appointments and admissions

We were concerned that complaints about the administrative pathway for our patients had increased—particularly during 2007/08 after the national 18-week referral to treatment target was introduced. Feedback from the Trust's Annual Members' Meeting in September 2009 also highlighted concerns relating to appointments for outpatient and elective (planned) surgery admissions.

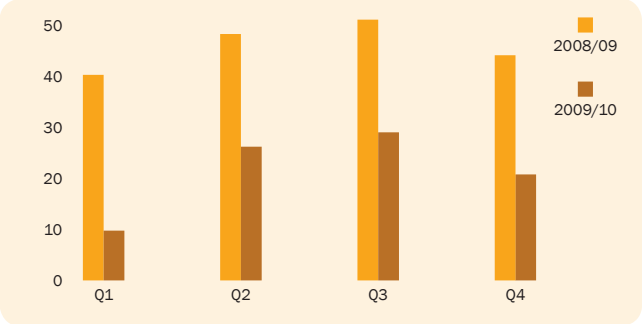
The administrative pathway is highly complex and so measuring improvement is challenging. We measure complaints in two key areas—the Appointments Office and the Admissions Office. The Appointments Office is responsible for booking all new outpatient appointments. The Admissions Office is responsible for booking nearly all adult elective surgical procedures.

In consultation with patients, our local PCTs and our own staff, we introduced much more flexibility into the Access Policy (which sets out the key principles of access to Trust clinical services). We upgraded the telephone system in February 2010 to enable a higher volume of calls to be answered in order to improve telephone waiting times, and the numbers of staff answering phones during the busiest times have been increased. We have also integrated the Admissions Office with the Appointments Office to provide a more efficient administrative pathway. These changes have had a significant impact as demonstrated by the tables below.

Complaints & concerns regarding Appointments Office



Complaints & concerns regarding Admissions Office



To improve the service further we are going to move the Admissions team onto the Appointments phone server and supply them with call centre phones. Phone calls can then be routed properly and the amount of calls taken can be monitored. We will encourage our patients to call us during less busy periods by including this information in patient letters. We will add a cancellation template to the Trust website so that patients can cancel appointments online. We will create a dedicated line for general enquiries in order to reduce the waiting times for patients calling.

Reduce Hospital Standardised Mortality Ratio (HSMR) by 5%

HSMR compares a Trust's number of actual deaths (mortality) with expected deaths. It is a calculation that takes into account a number of different factors that may affect mortality rates such as age, sex, diagnosis, length of stay and whether an admission was elective or emergency.

The factors are regularly reviewed and recalculated at intervals to take into account improvements in healthcare generally, for example to reflect the fact that people are on average living longer.

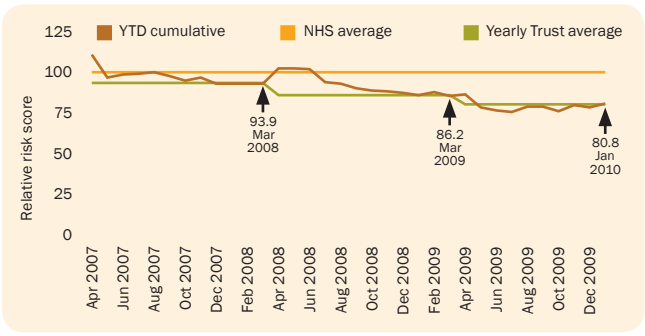
An HSMR of 100 means that the number of deaths is in line with expectations, an HSMR above 100 represents a higher mortality (death) rate, and an HSMR below 100 represents a lower mortality rate.

We have seen a steady reduction in our average HSMR over the past three years (see chart below) and we are currently ranked among the safest hospitals in England.

From a peak of 93.9 in March 2008, our cumulative HSMR in March 2009 was 86.2 and it reduced further to 80.8 in January 2010 (based on the most recent recalculation).

We did not achieve our planned 10% reduction for 2009/10, but we did achieve a 6% reduction, and we have set a target of a further 5% reduction this year.

HSMR year-to-date (YTD) cumulative historical performance (2008/09 benchmark)



This graph demonstrates the decrease in HSMR over the last three years using the current standardisation calculation and applying that retrospectively.

We have introduced a number of initiatives that have made a contribution to the reduction of our HSMR. These include the focus on identifying and responding to the deteriorating patient, reducing the incidence of venous thromboembolism (VTE), and reducing our infection rates in the Trust, most notably MRSA bacteraemia.

Our plans for 2010/11 include introducing a review of cases using the Institute for Healthcare Improvement (IHI) Global Trigger Tool (a tool for measuring adverse events) to identify areas for improvement, and a comparison of actual versus expected deaths by specialty.

HSMR as a comparator indicator between organisations is currently under national review and we will adapt our targets according to the outcome of this review.

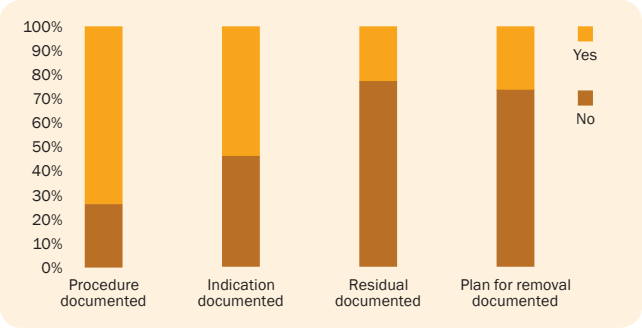
To be at or below the national average of patients with an indwelling urinary catheter and to reduce the number of urinary catheter days, excluding patients who need a lifelong urinary catheter

Urinary tract infections (UTIs) are one of the most frequently occurring hospital acquired infections—60–80% of UTIs are related to the presence of a urinary catheter. We know that approximately 20% of our patients will need a urinary catheter during their hospital stay and that the risk of developing a UTI increases by 5% each day a catheter remains in place. It is for this reason that we selected an indicator to reduce the number of catheter days within the Trust.

We undertook an audit of all adult wards in the Trust in 2009. A total of 264 patients were reviewed. We found that 17% of patients were catheterised and that the average length of time the catheter was in place was 10 days (range 1–25 days). The number of patients catheterised is an 11% reduction compared with our last audit in 2008 but is still higher than the national average of 12.5%.

The audit team found it difficult to establish an accurate baseline of the number of catheter days as there was a poor level of documentation of catheter information (see below). So although we have seen a significant reduction in the percentage of patients with a catheter, we do not know if we have seen a reduction in the number of associated catheter days.

Catheter documentation in patient records



We have introduced a number of initiatives with the aim of reducing the risks of developing a UTI and reducing the number of catheter days. The first of these initiatives was the introduction of short-term silver-alloy catheters in 2005. Silver-alloy reduces the risk of bacteria adhering to the catheter walls, which in turn reduces the risk of infection. In the past year we have introduced a new catheter policy which includes the use and introduction of bladder scanners. These are used to see if there is residual urine in the bladder before insertion. Catheters are then only inserted if urine is present in the bladder, leading to a reduction of unnecessary catheterisations.

We plan to continue auditing the frequency of use of urinary catheters and the number of urinary catheter days to establish a baseline. We will introduce the catheter care-bundle which is a set of interventions based upon Evidence Based Practice in Infection Control (EPIC) guidelines. These steps cover the insertion and ongoing management of a urinary catheter.

Quality and the business strategy

A commitment to quality is at the heart of what we do as an organisation. To ensure that our commitment to quality was embedded throughout the organisation in 2009/10 the Board explicitly set corporate objectives that reflected the quality imperative.

The Trust's corporate objectives to improve patient safety, clinical effectiveness and the patient experience mirror the three-part definition of quality in '*High quality care for all: NHS Next Stage Review final report*', published by Health Minister Lord Darzi in June 2008. As a Trust, we ensured that each of our directorates and departments showed how their local objectives were aligned with the Trust's corporate objectives in 2009/10.

For the 2010/11 financial year, the Trust Board has underlined its commitment to quality by maintaining the three corporate objectives from 2009/10 and adding a new objective to reflect the importance of financial and environmental sustainability:

- Improve patient safety and clinical effectiveness
- Improve the patient experience
- Deliver excellence in teaching and research
- Ensure financial and environmental sustainability

These corporate objectives are the basis for directorate and departmental objectives which ensure that there is alignment of objectives throughout the organisation so that quality is embedded in everything we do.

Workforce factors—how we embed quality

The NHS Constitution is integral to the Trust's workforce strategy. The Trust recognises that the four staff pledges identified in the NHS Constitution will help create and maintain a highly skilled and motivated workforce capable of meeting the Trust's corporate objective of improving the patient experience.

Pledge 1: Provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.

All staff should have an annual appraisal and personal development plan based on their objectives (which fit within directorate and departmental objectives)—the 2009 staff survey showed that 76% of staff had an appraisal in the past 12 months, giving the Trust one of the highest appraisal rates of any acute trust.

Pledge 2: Provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed.

The Trust runs more than 100 different learning courses and has a well-established first line management leadership course which includes a theme of managing quality running throughout the programme. All new staff attend the Trust's corporate induction and our Chief Executive leads a session

explaining the Trust's objectives, our approach to quality and what role staff can play in this.

This includes an outline of the Trust's vision which is 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.

Pledge 3: Provide support and opportunities for staff to maintain their health, well-being and safety.

Staff wellbeing is taken seriously and the Trust has a very low sickness absence rate (3.48%). Staff have access to fast-track musculoskeletal services and specialist counselling and we are actively pursuing further initiatives to support our staff to remain at work.

Pledge 4: Engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.

The Trust has developed a culture centred on quality. We have well-established methods of staff engagement including joint consultative frameworks and rigorous methods of communication, and the 2009 national staff survey confirms that we have significantly better communication between senior management and staff than most NHS trusts.

Leadership
We have recently completed an organisational restructure which increases clinical leadership, accountability, and shared responsibility with managers for delivery of services. It aims to empower clinical leaders at all levels in the Trust.

Student placements

The Trust provides placements for undergraduate medical, nursing, midwifery, physiotherapy, dietetics and occupational therapy students, as well as some volunteer placements for NVQ students.

Evaluations of all placements are carried out by our educational partners and results are fed back to the Trust via the programme and academic boards of the various universities at the end of each academic year. This feedback is then reviewed, necessary actions taken, and ideas for further development agreed. The Trust also organises its own local evaluations at the end of each placement for physiotherapy and is trialling this for midwifery with a view to expanding it to nursing.

A Trustwide placement group enables multi-professional placement data to be recorded which helps plan student capacity in order to provide learners with the best and most appropriate experience possible.

The Trust runs its own university co-ordinated mentorship course to train approximately 80 mentors annually for nursing and midwifery.

Innovation

We have a track record of innovation to improve quality—see below for three examples.

Medicines management

The rollout of electronic inpatient prescribing to reduce medicines-related risks continued in 2009/10—it now involves 24 out of 27 wards and it has had positive results. From October 2007 to May 2008 the following was demonstrated in the surgical wards:

- 52% increase in allergy documentation
- 77% decrease in medicines prescribed for patients to which they had a documented allergy on the medication chart
- 74% increase in compliance with the Trust's post-operative nausea and vomiting clinical guidelines
- 11% reduction in the severity of prescribing errors

We have demonstrated a sustained improvement in appropriate thromboprophylaxis prescribing from 32% in 2008/09 to 70% in 2009/10 due to an electronic trigger warning.

Since the rollout of electronic prescribing to medical and gynaecological wards we are confident these improvements will be realised across the Trust. In 2009/10 we continued to perform well and better than 2007/08 in all cases of allergy documentation and adherence to guidelines.

Antibiotic stewardship

We have a dedicated specialist pharmacy team working with microbiology, infection control nurses and clinicians to form the Antibiotic Management Team (AMT). The AMT reviews antibiotic prescriptions daily and provides advice to clinicians on antibiotic prescribing.

Antibiotic prescribing continued to improve in 2009/10 and, together with strong infection control practices, resulted in a 22% reduction in hospital associated *C. difficile* diarrhoea cases compared to 2008/09, substantially overachieving on Department of Health targets.

The Trust can demonstrate strong adherence to antibiotic guidelines through regular audits of antibiotic prescribing, with adherence consistently remaining above 90%. We have also exceeded the minimum target set by the PCT relating to antibiotic prescribing on discharge from hospital.

We introduced a user-friendly antibiotic pocket guideline for staff in August 2008 which has contributed to year-on-year reductions in the use of intravenous antibiotics—a 43% reduction from 2007/08 to 2008/09 and a further 13% reduction from 2008/09 to 2009/10.

The guide has also helped to reduce the risk of a patient receiving a penicillin-containing medication inappropriately by colour coding the medications according to whether they are a penicillin antibiotic or not.

Radiology

Since the installation of two new CT scanners, we have tried to improve the patient pathway and imaging experience. We have used the combination of advanced CT technology and innovative contrast injector software technology to optimise vascular opacification during the CT examination. This approach not only allows us to use lower strength contrast media but also to reduce the total contrast volume delivered to the patient. It has had a two-fold benefit for us in that not only does the patient benefit from reduced iodine volumes being administered but the department has seen financial benefit through reduced contrast use.

We have presented the benefits of using such innovative techniques at local and national conferences.

Our environment

We are fortunate to have a modern, well-designed hospital which is pleasant to work in. We benefit from an extensive range of art which contributes to a relaxed and pleasant environment for patients and visitors.

The Trust has an excellent reputation for cleanliness and infection control, reflected in consistently high Patient Experience Action Team (PEAT) scores and low rates of MRSA bacteraemia and *C. difficile*.

In order to maintain consistently high performance, the Trust runs internal PEAT visits on a regular basis involving clinical and non-clinical staff as well as patient representatives. These visits monitor cleanliness, patient dignity and food quality against the national PEAT standards and the results are reported quarterly to the Trust's PEAT Committee which is chaired by the Director of Nursing.

Additionally, all areas within the hospital are audited jointly on a monthly basis, with representatives from the Trust and the Trust's Facilities contractor who review and score the quality of the patient environment in clinical areas. Our internal target is that 90% of all clinical areas are jointly audited and performance is reported to the monthly PEAT Committee and the quarterly Facilities Committee.

The Trust also runs regular FEAT (Facilities Environment Action Team) visits to monitor non-clinical areas in the hospital. These are run every other month and results are reported to the Trust's Health, Safety and Fire Committee. The visits concentrate on monitoring and improving 'back of house' areas such as plant rooms and stairwells.

Annex 1: Statements from key stakeholders

NHS Kensington and Chelsea

The national Quality Account Toolkit defines the structure for NHS trusts to follow in preparing the Quality Account.

Chelsea and Westminster Hospital NHS Foundation Trust has followed this structure and the Quality Account is therefore consistent with the requirements.

Despite the curtailed timescales for comments, Chelsea and Westminster Hospital NHS Foundation Trust has consulted with NHS Kensington and Chelsea as regards to the content and the targets set within the Quality Account and has integrated the comments into their final Quality Account document.

The priorities that the Trust has set are broadly in line with the strategic priorities for the PCT for 2010/11 defined within its annual Business Plan, and on that basis the PCT is happy to endorse the targets that have been set.

Chelsea and Westminster Hospital NHS Foundation Trust has undertaken a long development process to agree and refine its proposals within the Quality Account, working closely with its Council of Governors who have taken a keen interest in the priority-setting and giving a users' perspective on the proposals.

The priorities include some areas where there is already work in place and some areas where there is separate monitoring as the priority is already a CQUIN target.

The Trust has considered priorities in each of the three key areas of clinical quality—safety, patient experience and effectiveness—showing a commitment to continuous improvement in standards of care across the board.

The priorities that the Trust has chosen are not viewed in isolation but in the context of the much wider work that the Trust is undertaking to improve patient care within the Trust. This is a consistently high performing Trust with an 'Excellent' rating from the Care Quality Commission for quality of care.

In the future, the PCT would seek to have a much less generic response to quality improvement and some sense that the Trust is understanding the segments of its user population and the differential impact that its quality improvement schemes may have.

The reduction in the inequalities experienced in some segments of the population within the Royal Borough of Kensington and Chelsea is a key priority for the PCT and all providers will be required to play their part in that.

The PCT will continue to work with the Trust to monitor the delivery of the proposed priorities and to assure itself that there is safe, effective care in place.

The Trust has a stated commitment to a focus on clinical audit as a tool for improvement and assurance. This focus would be fully endorsed by the PCT as a means of demonstrating outcomes of care as an integral part of the continuous improvement in quality.

Royal Borough of Kensington and Chelsea—Overview and Scrutiny Committee (OSC) on Health

The Overview and Scrutiny Committee was invited to comment on the Quality Report but was unable to do so within the available timescale because it ceased to exist on the day of the General Election, Thursday 6 May, and was

not reconvened until the Council's Annual General Meeting on Wednesday 26 May when it was created anew with many changes in membership.

Kensington and Chelsea Local Involvement Network (K&C LINk)

Kensington and Chelsea Local Involvement Network (K&C LINk) welcomes the opportunity to comment on Chelsea and Westminster Hospital NHS Foundation Trust's Quality Account.

We appreciate that this is the first year of Quality Accounts for the Trust and that the process was a steep learning curve for us all. The LINk would like to thank Trust staff for their support over the three-week consultation period and we look forward to more strategic partnership working in the coming year.

The LINk found the draft, in parts, difficult to read, lacking in data and unsuitable for the target audience. The LINk has received feedback from the Trust on a number of the issues raised in our full response but unfortunately this information was not timely for the consultative period available to us.

To summarise, the main issues of concern to K&C LINk in Chelsea and Westminster Hospital are:

- Stocking usage
- Patient satisfaction and complaint handling
- The administrative pathway including the 'Choose and Book' system
- Medicines management
- 'Mixed' wards
- Catheter usage

However, K&C LINk is looking forward to carrying out our 'dignity champion' assessments of nutrition and protected mealtimes on the wards in Chelsea and Westminster Hospital this summer.

Now that the project has been agreed, we are keen to ensure it has the full support of the Trust and continues to roll out in an efficient and effective manner.

As advised in previous communications, the K&C LINk wishes to strengthen the relationship it has with the Trust and has suggested establishing a formal liaison arrangement. We are happy to share the information and intelligence we collect and to offer our support to the Trust with patient and public involvement.

We suggest that we meet with a nominated representative in the near future to discuss joint-working possibilities, to share with you our LINk work-plan for 2010/11 and to discuss LINk involvement on public engagement committees.

We strongly recommend that the Trust considers its approach to the Quality Account process for 2010/11 now. Engagement with the public and patients, including the LINk, should be continuous throughout the year. Then the public, the target audience for the Quality Account, will have the opportunity to feedback in a timely and effective way throughout the year and to finalise feedback during the 30-day consultation period.

The Quality Account should also be more reflective of local priorities as a result. We look forward to hearing from you.

The Trust publicises protected mealtimes for patients

Annex 2: Glossary

Abbreviation	Meaning/definition
ABO	ABO blood group system (A, B, O, AB)
AMT	Antibiotic Management Team
BEACH	Bedside Emergency Assessment Course for HCAs (Healthcare Assistants)
CABG	Coronary Artery Bypass Graft
CEMACE	Centre for Maternal & Child Enquiries
CEWSS	Chelsea Early Warning Scoring System
CIN	Cervical Intra-Epithelial Neoplasia
CQUIN	Commissioning for Quality and Innovation
CXR	Chest X-Ray
DAHNO	Data for Head & Neck Oncology
DAT	Direct Antiglobulin Test
DEBM	Donor Expressed Breast Milk
EPIC	Evidence Based Practice in Infection Control
FBS	Fetal Blood Sampling
HSIL	High-grade Squamous Intraepithelial Lesions
HSMR	Hospital Standardised Mortality Ratio
ICNARC CMP	Intensive Care National Audit & Research Centre—Case Mix Programme
IHI Global Trigger Tool	An international tool developed by the Institute for Health Improvement which uses triggers or clues to identify adverse events/incidents and is effective for measuring the overall level of harm in a healthcare organisation.
IMB	Inter-Menstrual Bleeding
LINk	Kensington and Chelsea Local Involvement Network
MDT	Multi Disciplinary Team
MEBM	Maternal Expressed Breast Milk
MINAP	Myocardial Ischaemia National Audit Project
NAPTAD	National Audit of Psychological Therapies for Anxiety and Depression
National inpatient survey problems score	A tool used for admitted patients to assess their satisfaction levels against an agreed criteria. It is used to assist healthcare organisation to identify areas for improvement.
NBOCAP	National Bowel Cancer Audit Programme
NCEPOD	National Confidential Enquiries into Patient Outcome and Death
NDA	National Diabetes Audit
NEC	Necrotizing Enterocolitis
Never Events	Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
NHFD	National Hip Fracture Database
NHS CSP	NHS Cervical Screening Programme
NICE	National Institute for Clinical Excellence
NICU	Neonatal Intensive Care Unit
NIHR	National Institute of Health Research
NJR	National Joint Registry
NLCA	National Lung Cancer Audit
NNAP	National Neonatal Audit Programme

Abbreviation	Meaning/definition
NPSA	National Patient Safety Agency
PALS	Patient Advice & Liaison Service—a department found in every NHS hospital with the responsibility of attending to any concerns by patients and/or carers.
PCB	Postcoital Bleeding
PCEA	Patient Controlled Epidural Analgesia
PEAT	Patient Environment Action Team
PET	Patient Experience Tracker
PMB	Post Menopausal Bleeding
Problem scores	Problem scores are an interpretation of the data made by the Picker Institute. Any comparisons made within the Trust (internal benchmarks, historic comparisons) or between trusts (external benchmarks) are made using these scores. The problem score shows the percentage of patients for each question who, by their response, indicated that a particular aspect of their care could have been improved. They are calculated by combining response categories. For example, for the following question 'Did you have confidence and trust in the doctors treating you?' the responses 'Yes, sometimes' and 'No', have been combined to create a single problem score.
PROMs	Patient Reported Outcomes Measures—measures of health status or health-related quality of life that come directly from patients.
PSF intervention	Patient Safety First intervention—see www.patientsafetyfirst.nhs.uk
RCP	Royal College of Physicians
Secondary Uses service	Provides anonymous patient-based information for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.
SCJ	Squamocolumnar Junction
TARN	Trauma Audit & Research Network
Proton Pump Inhibitors	Drugs that reduce the secretion of gastric (stomach) acid
Revascularisation waiting time	The length of time a patient waits before having a surgical procedure for the provision of a new, additional, or augmented blood supply to a body part or organ.
Peri-arrest	A type of cardiac arrest related to irregular heart beats (arrythmias) due to malfunction of the heart.
Stretch targets	Set beyond average, achievable target through attaining extremely high standards.
Urinary catheter care bundles	A documentation tool with an outlined sequential care plan which ensures that all significant interventions for the care and management of patients with urinary catheters are not missed. This enables implementation of standardised best practice and prevent/reduce adverse events.

One of the hospital atriums

Performance Report

A member of staff helps a patient use the Trust's new Patient Experience Tracker (PET) to give feedback on our services

Key facts

There was increased demand for Trust services in 2009/10:

Number of patients treated

	2009/10	2008/09	2007/08
Inpatients	**38,751**	37,644	36,729
Outpatients	**262,116**	259,916	247,525
Day cases	**17,790**	16,821	15,962
A&E	**100,905**	97,640	97,685
Total	**419,562**	**412,021**	**397,901**

In particular, there was increased demand for our specialist services:

- 5,497 deliveries in Maternity in 2009/10, compared with 5,311 in 2008/09 and 5,177 in 2007/08
- 86,922 children treated in 2009/10 as inpatients, outpatients, in Paediatric A&E or as day case patients, compared with 83,921 in 2008/09 and 82,478 in 2007/08
- 6,005 people living with HIV on our caseload in 2009/10, compared with 5,481 in 2008/09 and 5,444 in 2007/08

There were also high levels of satisfaction with Trust services:

- 90% of patients rated their care at Chelsea and Westminster as 'Excellent', 'Very good' or Good' in the annual NHS inpatient survey 2009
- Chelsea and Westminster was rated as the fourth best performing hospital in England for patient safety in the Dr Foster Hospital Guide 2009
- Standards of hospital hygiene (environment), privacy and dignity, and food were all rated 'Excellent' in the National Patient Safety Agency's Patient Environment Action Team (PEAT) assessment 2010

Principal activities of the Trust

The Trust is a Central London teaching hospital, providing specialist services in a range of specialties including Paediatrics, HIV & Sexual Health and Burns, and general hospital services to the local population.

Chelsea and Westminster is a campus of Imperial College London School of Medicine.

Most services are at Chelsea and Westminster Hospital but HIV & sexual health services are provided at the St Stephen's Centre next to the main hospital building, 56 Dean Street in Soho, and the West London Centre for Sexual Health at Charing Cross Hospital.

The Trust is also increasingly providing community-based services—for example, in 2009/10 we won competitive tendering exercises to provide community gynaecology and community dermatology services in Westminster.

Clinical services are divided into three divisions, each led by a Divisional Clinical Director and a Divisional Director of Operations. Facilities services are contracted out to ISS Mediclean and Norland Managed Services.

Review of financial performance

In 2009/10 the Trust's financial performance was given a financial risk rating of 4 out of 5 by Monitor, where 5 is 'low risk', and delivered a surplus of £7.0 million which was ahead of the planned surplus of £6.4 million—the Trust expects to be 'Excellent' for 'Quality of Financial Management' in the annual performance ratings published in October 2010. This will be the fourth successive year that the Trust has delivered an 'Excellent' financial rating since becoming a Foundation Trust in October 2006.

The Trust's annual income and expenditure performance is set out in Table 1.

Table 1: Summary 2009/10 Income and Expenditure Outturn vs Plan (£m)

	Plan 2009/10	Actual 2009/10	Variance 2009/10
Income			
Clinical Income	265.2	**267.3**	2.1
Non-Clinical Income	38.4	**41.2**	2.8
Total Income	**303.6**	**308.5**	**4.9**
Expenses			
Pay Costs	-157.0	**-159.1**	-2.1
Non-Pay Costs	-120.4	**-125.8**	-5.4
Total Expenses	**-277.4**	**-284.9**	**-7.5**
EBITDA	**26.2**	**23.7**	**-2.6**
Depreciation	-10.0	**-7.4**	2.6
Dividend on PDC	-9.2	**-8.6**	0.6
Interest	-0.7	**-0.5**	0.2
Loss on Disposal of Asset		**-0.2**	-0.2
Net surplus	**6.4**	**7.0**	**0.6**
Cost Improvement Porgramme (CIP)	**10.5**	**8.7**	**-1.8**

Key variances from plan in 2009/10

1. NHS clinical income was £2.1 million above plan due to activity over-performance across most specialties.

2. Non-clinical income was £2.8 million above plan mainly due to increased income from facilities charges and education and training.

3. Pay costs were £2.1 million higher than plan, primarily due to increased clinical activity which was in excess of plan, resulting in short-term staffing solutions and increased spend on temporary staffing. During the year the Trust put in place robust management controls on temporary staffing and the usage of nurse agency hours was reduced by 37% from the start of the year.

4. Non-pay costs were £5.4 million higher than plan because of increased costs of drugs, other clinical supplies and increased use of high-cost laparoscopic (keyhole) surgical techniques.

5. Depreciation and dividend costs were underspent by £2.6 million and £0.6 million respectively due to recognition of 50% residual value of Trust assets in line with independent valuations.

6. Net interest received was £0.2 million less than plan due to lower interest rates than originally planned as a result of the economic downturn.

7. 84% of the planned cost improvement programme was delivered during 2009/10. This shortfall was offset partly by increased levels of income and partly by the reduction in depreciation and dividend costs previously stated.

Panoramic view from the roof of the hospital

Review of non-financial performance

The Trust was rated 'Excellent' for both 'Quality of Services' and 'Quality of Financial Management' in the annual performance ratings published by the Care Quality Commission in October 2009 which measured performance in 2008/09.

Only 37 out of 392 NHS trusts in England achieved a double 'Excellent' rating which meant we were ranked among the top 9% of NHS trusts in England.

NHS Chief Executive, David Nicholson, and Care Quality Commission Chairman, Barbara Young, wrote a letter of congratulations to staff which named Chelsea and Westminster among 41 trusts nationally that had performed strongly in the performance ratings for two years in a row.

We were compliant with 43 of 44 core standards, met seven of eight indicators measuring performance against long-standing government targets mainly concerned with waiting times and access to services, and met all 13 indicators measuring performance against the government's national priorities including overall patient experience, MRSA bacteraemia rates, cancer targets and stroke care.

In 2009/10, the Care Quality Commission rated the Trust's quality of care against 21 indicators and we were able to measure how we performed against 19 of the 21 indicators throughout the year—on the basis of this ongoing monitoring, we predict we will achieve a maximum score for all 19 indicators when annual performance ratings are published in October 2010.

The Care Quality Commission will allocate scores for the remaining two indicators (staff satisfaction and patient experience) based on the results of the national staff survey and the national inpatient survey before confirming our overall 'Quality of Services' rating.

The Trust is therefore hopeful of retaining its 'Excellent' rating for 'Quality of Services' in this year's NHS performance ratings.

The popularity of the Trust's services was confirmed by the results of the annual NHS inpatient survey 2009 which were published in May 2010—90% of patients rated our services as 'Excellent', 'Very good' or 'Good'.

Developments since the end of 2009/10 financial year

Developments since 31 March 2010 have been focused on three main areas:

- *Putting Patients First*—redevelopment of Chelsea and Westminster Hospital
- *Fit for the Future*—10% cost improvement programme in 2010/11 as agreed by the Board of Directors
- Other developments

Putting Patients First

A £39 million redevelopment of the hospital aims to improve services for patients and secure our future as a specialist hospital.

A two-storey extension to the first and second floors of the hospital will help us to achieve the Trust's vision of providing world class children's services following our designation as the lead centre for specialist paediatric and neonatal surgery in North West London, while also developing further our HIV services.

As part of the redevelopment, many outpatients services will be moved to the lower ground floor of the hospital and other departments will need to move off-site, in order to maximise space on the hospital site for clinical care.

Key developments since the end of the 2009/10 financial year include:

- BAM Construction, the Trust's building contractor on the redevelopment to improve children's services and HIV services, started work on site on 26 April 2010
- The Preoperative Assessment Centre moved from the first floor to the lower ground floor on 4 May 2010, the first stage of the relocation of most outpatients services to create an integrated, 21st century service

Fit for the Future

The Trust has launched a structured internal communications campaign called *Fit for the Future* with staff about why the Trust must maintain and improve the quality of patient care while delivering 10% cost savings in 2010/11.

This campaign builds on engagement with staff to help identify Trustwide cost savings since the need to save 10% in 2010/11 was identified in autumn 2009.

Our challenge, in common with all other NHS organisations, is how to achieve savings without compromising quality—in other words, how to make Chelsea and Westminster *Fit for the Future*.

A key development since the end of the 2009/10 financial year was the implementation of the *Fit for the Future* approach in the newly created Medicine and Surgery Division.

The divisional management team, led by the Divisional Clinical Director and the Divisional Director of Operations, invited all staff to an open meeting in April 2010.

The main aim is to promote closer working across the emergency and elective pathways in Medicine and Surgery including:

- A new combined Acute Assessment Unit to provide acute care for medical and surgical patients, replacing the current Acute Medical Unit
- An enhanced Weight Loss Surgery recovery area on a ward
- An emergency surgery taskforce to improve patient access to emergency surgery and reduce length of stay
- A day case procedure taskforce focusing on increased use of the Surgical Admissions Lounge
- Development of closer collaborative working arrangements with partner organisations including Social Services to improve transfers and prevent unnecessary admissions

This closer working—as well as the national policy drive to provide more care in the community rather than in acute hospitals—means less inpatient beds are needed and so St Mary Abbots Ward will close with effect from 1 July 2010.

A formal consultation with staff directly affected by the proposal to shut the ward is underway. Due to the number of staff vacancies across the Division, it is anticipated that no redundancies will be necessary.

Other developments

- The Trust's new organisational structure of three clinical divisions, each led by a Divisional Clinical Director and a Divisional Director of Operations, came into full effect on 1 April 2010—it aims to ensure doctors are in positions of leadership and responsibility
- Our revamped Assisted Conception Unit was officially opened on 8 May 2010 by the BBC presenter and journalist Sophie Raworth—she praised the quality of care she received on the Maternity Unit while having her three children at Chelsea and Westminster
- More than 1,500 people attended the hospital Open Day on 8 May 2010—97% of visitors who used our Patient Experience Tracker (PET) devices to give feedback rated the Open Day as 'Excellent' or 'Good'

Future developments

Putting Patients First

The redevelopment of the hospital will continue in 2010/11.

Work on converting space on the lower ground floor of the hospital into a new location for most outpatients services is due to start after staff who are currently based in this area vacate the space in August 2010. The new area is due to open in February 2011.

The Trust's vision for this new 21st century outpatients service is to maximise the use of technology, provide patients with an 'airport' style facility in which bookings and appointments are easy and logical, and ensure that clinical teams work to standardised, efficient administrative processes.

Some staff who currently work on the lower ground floor will be required to move from the main hospital site to off-site office accommodation in order to facilitate the redevelopment.

Off-site options are currently being explored by the Trust. The Trust is committed to communicating information to all staff affected as soon as possible.

Fit for the Future

Changes in the Medicine and Surgery division will be implemented in 2010/11 including the development of an Acute Assessment Unit and increased use of the Surgical Admissions Lounge.

Trustwide in 2010/11 there is a cost improvement programme target of £22.6 million which equates to a need to make 10% cost savings.

Maintaining and improving the quality that patients experience from the Trust while delivering significant cost savings during these difficult economic times will have a major impact on all areas of the organisation.

Other developments

- The Trust is bidding to provide community dermatology services in Kensington and Chelsea following the success in 2009/10 of the Trust's bids to provide community dermatology and gynaecology services in Westminster
- We will explore opportunities to bid to provide other community services in order to expand the Trust's portfolio of 'out of hospital' care
- The Trust will also consider possible future opportunities to bid to take over the running of a PCT's provider function or to explore the possibility of acquiring another provider organisation (hospital)
- We are working jointly with NHS Kensington and Chelsea on a 'preferred provider' basis to develop a model of care and an implementation plan for an Urgent Care Centre, co-located with the A&E at Chelsea and Westminster, to which non-emergency patients will be redirected
- The London and South East of England Burns Network has announced a strategic review of burns care, to be undertaken by Commissioning Support for London—development of the Burns Unit at Chelsea and Westminster is aligned with our strategic positioning as a specialist hospital and the Trust intends to bid if services are formally tendered following the review process

Principal risks & uncertainties facing the Trust

The Trust has effective mechanisms in place to manage risk, in accordance with its risk management policy and strategy, supported by two committees with Board accountability—the Audit Committee and the Assurance Committee.

The Trust has a very challenging cost improvement programme target of £22.6 million (10%) in 2010/11 to ensure that the Trust can maintain an 'Excellent' rating for 'Quality of Financial Management' in the Care Quality Commission's annual performance ratings for 2010/11.

The main reasons for this are:

- Expected losses in income due to tariff changes and a reduction in the Market Forces Factor
- Impact of demand management schemes as commissioners shift routine outpatient work into the community
- Funding for the Trust's capital development programme of c. £100 million over the next three years

A risk is that, if £22.6 million of savings are not identified, the Trust will have to underspend in other areas to compensate.

Uncertainties are future economic conditions and their impact on public sector spending under a new coalition government.

A major uncertainty is that as yet there is no confirmed strategy for the reconfiguration of services within North West London. The Trust is working closely with the North West London Commissioning Partnership to support its work and mitigate risks to the Trust's activity, particularly relating to any review of paediatric inpatients activity or adult emergency surgery.

The drive to move services from acute settings to community-based polysystems is a risk to the Trust although it is mitigated in part by the Trust's success in bidding to provide community services and its strategic aim to continue to bid for tenders to provide other community services.

The setting up of an Urgent Care Centre to take on a large amount of activity from A&E is also a risk to the Trust but it is mitigated by our 'preferred provider' status for providing the service and by the fact that the anticipated impact on A&E activity may not be realised in full, at least in the short-term.

Trends & factors likely to affect the Trust's future performance

National trends

The need to ensure sustainability of shorter waiting times in line with the national 18-week referral to treatment target will continue to be a key focus, particularly because achieving this target at specialty level remains a significant challenge.

The Trust is planning for a slowdown in public sector spending as a result of the economic downturn. The impact of this trend on the Trust will be a key focus in 2010/11 and beyond.

Regional trends

We expect the North West London Commissioning Partnership to finalise its strategy for the reconfiguration of services within the sector in 2010/11 in line with the principles of Lord Darzi's report *Healthcare for London: A Framework for Action*—this strategy will have a significant impact on the Trust.

As a Foundation Trust, we are considered a 'fixed point' in North West London and therefore options are being explored about potentially acquiring another NHS trust or taking over the management of a PCT's provider function.

The Board of Directors is clear that any potential acquisition needs to be explored carefully to ensure that it benefits patient care and the NHS trusts involved. Any potential acquisition would receive due diligence from the outset.

Reconfiguration of HIV inpatient services in London is expected in 2009/10—the Trust has a national and international reputation in this specialty and is in a strong position to bid to be designated as an inpatient facility if this approach is taken by the commissioners.

Local trends

The development of polysystems and the transfer of services to the community is a growing trend that will affect the Trust. We are bidding in partnership with The Royal Marsden NHS Foundation Trust for community services in Richmond and Hounslow.

The Trust is also currently bidding to provide community dermatology services in Kensington and Chelsea and we plan to bid to provide community cardiology, sexual health, musculoskeletal and older people's services in Kensington and Chelsea if, as expected, they are tendered in 2010/11.

The £39 million redevelopment of the main hospital will be a key local focus this year—the new location for outpatients services on the lower ground floor is due to open in February 2011.

The Trust will aim to expand its Maternity Unit further this year with the aim of increasing the number of deliveries to 6,000 by 2012/13, in line with our strategic positioning as a specialist provider.

The opening of the Urgent Care Centre at Chelsea and Westminster, for which the Trust is the 'preferred provider', will have an impact on activity in the A&E Department.

Research & Development

Delivering excellence in teaching and research was a key corporate objective in 2009/10 (as it is in 2010/11).

In 2009/10, the Trust led a successful bid to establish and host the North West London Health Innovation and Education Cluster (HIEC).

HIECs are partnerships between NHS organisations, universities, voluntary organisations and industry to promote innovation, quality and productivity in the NHS through training and education of healthcare staff. They aim to ensure that patients see the benefits of research and innovation through better care and treatment.

North West London HIEC is hosted at Chelsea and Westminster and partner organisations include the Royal Marsden and Royal Brompton hospitals, Imperial College London, other NHS trusts, and Macmillan Cancer Care.

Since it was announced that the Trust's bid had been successful in December 2009, two initial projects have been scoped—the use of telemonitoring to support heart failure patients in the community and how best to support staff working with cancer patients in the community.

The Trust also continues to host the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Northwest London.

This £20 million project—£10 million from the National Institute for Health Research matched by £10 million from CLAHRC organisations in North West London—aims to lead to the rapid introduction of new, effective treatments for a wide range of medical conditions.

The Trust is participating actively in CLAHRC research projects including hospital discharges of patients with chronic obstructive pulmonary disorder (COPD) and HIV/Hepatitis C testing in A&E and primary care.

The Trust Chairman, Professor Sir Christopher Edwards, chairs the Trust's Research Strategy Board. The Trust's Research Strategy, *Improving Patients' Lives Through Research and Innovation*, was developed in 2009/10 and is due to be approved and implemented in 2010/11.

Our staff

The Trust employs more than 2,700 staff. The Trust's corporate objective for 2009/10 of improving the patient experience included an aim to develop a motivated, trained, capable and competent workforce.

There was a marked increase in the response rate to the annual NHS staff survey—65% of staff took part in the survey. See the 'Staff survey' section on page 58 for full details of the survey results.

The Trust is committed to staff development and celebrating the achievements of our staff. Customer service training is provided for all new staff joining the Trust.

We also have an annual Christmas Cheer Awards and a monthly Team/Employee of the Month Award which gives staff and patients an opportunity to nominate staff who go the extra mile in their working lives.

Patient care

Foundation Trust status

A key benefit of Foundation Trust status is that the Trust can retain its financial surplus to reinvest in services.

Part of the Trust's surplus in 2007/08 helped develop 56 Dean Street, a new £2 million HIV and sexual health centre in Soho which opened to patients in March 2009.

56 Dean Street is now the busiest sexual health centre in London, according to Department of Health statistics for the three months from December 2009 to February 2010.

The centre also diagnoses 20% of all new HIV cases among gay men in London.

Another key benefit of Foundation Trust status is financial flexibility.

Funding of £39 million for the first major redevelopment of Chelsea and Westminster Hospital since it opened in 1993 was secured through the Foundation Trust Finance Facility.

The redevelopment aims to enable the Trust to provide world class children's services following our designation as the lead centre for specialist paediatric and neonatal surgery in North West London, develop further our internationally renowned HIV services, and create a 21st century outpatients facility.

Another benefit of Foundation Trust status is the positive engagement with our local community engendered by our 15,000 members and the Governors who they elect as their representatives.

Our members and Governors played an important role in supporting our successful campaign to be designated as a stroke unit during a three-month public consultation by Healthcare for London which ended in May 2009.

Governors were involved in development of the Trust's strategy in 2009/10, both at their quarterly meetings and at workshops and sessions with the Executive team.

The Annual Members' Meeting in September 2009 was both well-attended and a valuable forum for discussion of important issues, while the continued popularity of our annual Open Day demonstrates a high level of public interest in the hospital.

Performance against key patient targets

The Trust met all key national targets in 2009/10 and improved patient care by, for example, treating a record number of people and reducing infection rates.

We met a challenging national target of treating 95% of outpatients and 90% of inpatients within 18 weeks of GP referral, not only Trustwide but also at specialty level.

This achievement was made possible by the hard work and expertise of staff, despite increasing patient numbers—419,562 in 2009/10 compared with 397,901 in 2007/08—and the harshest winter for many years.

We also achieved a national target of treating 98% of A&E patients within four hours, again following the busiest year on record—100,905 patients were treated in A&E during 2009/10 including 32,295 in our dedicated 24-hour Paediatric A&E which continues to be increasingly popular with parents.

The Trust significantly outperformed national targets for the reduction of both MRSA bacteraemia and *Clostridium difficile*.

The Trust had just 10 cases of MRSA bacteraemia—against a target of 19 cases set by the Care Quality Commission—and 32 cases of *C. difficile*—against a target of 109 cases set by the Care Quality Commission.

Targets agreed with local commissioners

In 2009/10, 0.5% of the value of our main acute contract income was conditional upon goals agreed with our host commissioner, NHS Kensington and Chelsea, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

These targets included zero MRSA bacteraemia infections for elective surgery patients, an accelerated rollout of the Trust's Patient Experience Tracker (PET) to collate real-time patient feedback, and the rollout of electronic discharge summaries to GPs in Hammersmith and Fulham, and Westminster.

CQUIN payments were also agreed for specialist work in HIV and neonatal intensive care, and for community services in paediatrics, dermatology and gynaecology.

The Trust achieved 93% of CQUIN-related goals in 2009/10.

In 2010/11, five key questions from the national inpatient survey relating to the need to be more responsive to the personal needs of patients have been chosen as national indicators under the CQUIN payment framework.

Monitoring quality improvements

Progress towards meeting national and local targets is reported to the Board of Directors and any action required to meet targets is approved as appropriate.

For example, action plans were developed for approval by the Trust Board in response to the Trust's performance in the national inpatient and staff surveys.

New or significantly revised services

The Trust's new HIV and sexual health centre in Soho—56 Dean Street—was officially opened in May 2009. It provides a wide range of services for patients in a modern environment utilising the latest technology and offering improved access to services including Saturday and evening opening hours.

Statistics for 2009/10 show that relocating the centre from Vincent Square, SW1 to Soho has been a huge success. There was a 40% year-on-year increase in sexual health clinic attendances and the number of infections diagnosed also rose sharply, for example a 103% increase in chlamydia diagnoses and a 185% increase in gonorrhoea diagnoses.

A new community mobile health clinic was launched in February 2010, initially providing health screening and advice targeted at men attending Chelsea Football Club home games at Stamford Bridge.

The Surgical Admission Lounge was officially opened in October 2009 by patient Patricia Rowley—the new facility aims to improve the experience of patients being admitted to the hospital for elective surgery.

The Trust successfully bid to provide, and implemented, community gynaecology and dermatology services in Westminster.

In addition, a number of services have been significantly revised or improved:

- Following the Trust's designation as a stroke unit, after Healthcare for London's public consultation in 2009, a capital scheme has expanded the unit to 22 beds to support the provision of the service at the required level
- An extensive refurbishment of the Neonatal Intensive Care Unit was completed to expand its capacity to 42 cots to support the Trust's high risk maternity and complex specialist paediatrics activities
- The Trust's Assisted Conception Unit has been revamped to provide an enhanced environment for patients and was officially opened in May 2010

Service improvements following patients' concerns and complaints

In April 2009 a new two-stage complaints process for health and social care comments, concerns and complaints was implemented nationally.

All complaints and concerns are logged and reported to the Board of Directors on a quarterly basis. Previously concerns raised via M-PALS were reported separately to concerns raised as formal complaints.

There is also a greater emphasis on local resolution of concerns raised in clinical directorates to ensure a timely and local response rather than immediately referring them to the Complaints or M-PALS team.

The quarterly report to the Board of Directors captures all concerns raised through both M-PALS and Complaints and analyses the data to ensure any trends or areas of concern are identified and an appropriate action plan is in place.

An important aspect of handling complaints is listening to patients' views, observing what and where things are going wrong, and changing practice to improve services. It is important that lessons learned from complaints are shared across the Trust and used to enhance the quality of services for the future.

The following are examples of improvements that have been made to services in response to concerns and complaints:

Medicine

- An additional staff member for the secretarial team in Neurology will be recruited to ensure there are no delays in the typing and sending of discharge summaries and clinic letters

Surgery

- The Emergency Hand Trauma pathway has recently been reviewed with the Clinical Nurse Specialist playing a key link role between the surgical team and the A&E Department

Women's & Children's Services

- Measures have now been put in place to ensure that specific dietary requirements for unplanned admissions can be ordered directly with the Trust's catering provider when a dietitian is not available (eg weekends and Bank Holidays)

Anaesthetics & Imaging

- New signs have now been put up in the Phlebotomy Department to inform parents that if their child is under 5 they should report to Paediatrics for blood tests

Pharmacy

- New posters have been put up in the Pharmacy Department informing staff and patients that representatives of patients who are waiting for medication, following a discharge, can collect it on behalf of the patient if permission is sought from the pharmacy staff on the discharging ward.

Improvements in patient/carer information

The Trust's Patient Experience Tracker (PET) to collect real-time patient feedback was rolled out to inpatient and outpatient areas in 2009/10—by March 2010 the Trust had achieved a 76% response rate for inpatient areas.

New sponsored electronic patient information screens were installed in three locations in the hospital in March 2010. They provide useful health information and they also benefit the Trust financially because we receive a percentage of the sponsorship revenue.

The Trust improved information for people with learning disabilities, in line with a Care Quality Commission performance indicator.

A 'Patient Passport' was produced to support people with learning disabilities who come to Chelsea and Westminster—copies were distributed to wards and departments for staff to use with patients who have learning disabilities.

As part of its ongoing commitment to reducing accessibility barriers, the Trust enabled an innovative new product called BrowseAloud on its website.

BrowseAloud helps people who have literacy problems, learning difficulties, dyslexia, mild visual impairments or who speak English as a second language by reading aloud all website content. There is no charge for users.

Redevelopment of the Trust website was rolled out during 2009/10 to improve the quality of information available about our services to patients and carers online. The website project will be completed in 2010/11.

Children's Services staff pictured with one of the Trust's new sponsored electronic patient information screens

Stakeholder relations

The Trust has maintained and strengthened its relationships with key stakeholders including NHS, local authority and education partners.

Key stakeholders have nominated representatives on the Council of Governors which also includes elected representatives of patients, members of the public living in our four local boroughs, and Trust staff.

Key stakeholder organisations are invited to take part in the annual hospital Open Day—teams of staff from 17 partner organisations and nine charities associated with the Trust took part in the Open Day in May 2010.

Both our local MPs, Greg Hands and Sir Malcolm Rifkind, have taken a keen interest in the hospital and also attended the Open Day for the last two years.

We work closely with our host commissioner, NHS Kensington and Chelsea, and increasingly with the North West London Commissioning Partnership.

The Trust works closely with the Royal Borough of Kensington and Chelsea, in particular the Health Overview and Scrutiny Committee.

In 2009/10 the Trust worked in partnership with its neighbouring NHS organisations on Fulham Road—Royal Brompton & Harefield NHS Foundation Trust and The Royal Marsden NHS Foundation Trust—on specific project workstreams with the aim of realising 'back office' efficiencies.

North West London PCTs designated Chelsea and Westminster as the hub for neonatal and specialist paediatric surgery in the sector in May 2009 following a bidding process during the 2008/09 financial year.

Our focus in 2009/10 was on mobilising the specialist paediatric surgical network across North West London by, for example, hosting stakeholder events and launching the clinical network board.

The Trust has developed a federated model of care along defined clinical pathways with key partners including Great Ormond Street Hospital, Guy's and St Thomas' NHS Foundation Trust, and Royal Brompton & Harefield NHS Foundation Trust.

The Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Northwest London and the North West London Health Innovation and Education Cluster (HIEC) are both hosted at Chelsea and Westminster.

Both the CLAHRC and HIEC involve partnership working with key stakeholders in the NHS and other sectors.

The CLAHRC aims to facilitate the rapid introduction of new, effective treatments for a wide range of medical conditions while the HIEC promotes innovation, quality and productivity in the NHS through training and education of healthcare staff so that patients benefit from better care and treatment.

Staff and patients from the children's and young people's engagement forum held in April 2010 to consult about the redevelopment of our Children's Services

Governance Report

NHS Foundation Trust Code of Governance

Chelsea and Westminster Hospital NHS Foundation Trust is committed to effective, representative and comprehensive governance which secures organisational capacity and the ability to deliver the mandatory goods and services. The Trust's governance arrangements reflect components of good practice distilled from consultation and widespread experience.

These disclosures give a clear and comprehensive picture of the Trust's governance arrangements and illustrate the application of the main and supporting principles of the Code as a criterion of good practice.

It is the responsibility of the Board of Directors to confirm that the Trust complies with the provisions of the Code or, where it does not, to provide an explanation which justifies departure from the Code in the particular circumstances.

For the year ending 31 March 2010 Chelsea and Westminster Hospital NHS Foundation Trust complied with all the provisions of the Code of Governance published by Monitor in September 2006 with the following exception which the Board of Directors considers to be sound and justified in the circumstances:

C.2.1: Approval by the Council of Governors of the appointment of a Chief Executive should be a subject of the first general meeting after the appointment by a committee of the Chairman and Non-Executive Directors.

Reappointment by the Non-Executive Directors followed by re-approval by the Council of Governors thereafter should be made at intervals of no more than five years.

All other Executive Directors should be appointed by a committee of the Chief Executive, the Chairman and Non-Executive Directors and subject to reappointment at intervals of no more than five years.

Response: The Trust does not comply with this provision in so far as the Chief Executive and other Executive Directors are not subject to reappointment at intervals of not more than five years.

The Chief Executive and other Executive Directors are permanent employees of the Trust with employment contracts in force prior to authorisation as a Foundation Trust.

The Board of Directors conducts robust annual appraisals of its Chief Executive and other Executive Directors and does not consider that five-year contracts will be competitive and enable the Trust to recruit and retain the best talent.

Board of Directors

Composition of the Board

The Board has six Non-Executive Directors (including the Chairman) and five Executive Directors (including the Chief Executive)—the Director of Governance & Corporate Affairs attends Board meetings as Company Secretary.

The appointment of the Chairman and appointment/reappointment of Non-Executive Directors is approved by the Council of Governors. The appointment of the Chief Executive is by the Non-Executive Directors, subject to approval by the Council of Governors.

See page 46 for details of the Board including each Director's name, role or job title, responsibilities, a brief description of their background and length of appointment (Non-Executive Directors only).

Balance of Board membership & independence

The Board of Directors is satisfied that its balance of knowledge, skills and experience is appropriate to the Board and its sub-committees.

The Board has evaluated the circumstances and relationships of individual Non-Executive Directors which are relevant to the determination of the presumption of independence.

The Board determines all of its Non-Executive Directors to be independent in character and judgement. A Non-Executive Director is appointed as a representative of Imperial College London, the Trust's partner in medical education. However, the Board remains confident that, in spite of this relationship, this Director's judgement is not likely to be affected.

Performance evaluation

The annual appraisal of the Chairman involves collaboration between the Senior Independent Director and the Deputy Chairman of the Council of Governors to seek the views of both Executive Directors and Governors. Executive Directors have an annual appraisal with the Chief Executive. The performance of Non-Executive Directors is evaluated annually by the Chairman.

Access to register of Directors' Interests

Members of the public can gain access to the register of Directors' interests by making a request to the Foundation Trust Secretary, Chelsea and Westminster Hospital NHS Foundation Trust, 369 Fulham Road, SW10 9NH, via email ftsecretary@chelwest.nhs.uk or on 020 8846 6716.

Board meetings

The Board meets regularly, on average once a month. Special meetings are convened as and when required. There were 10 ordinary meetings and one special meeting in 2009/10.

Directors' attendance at Board meetings 2009/10

Non-Executive Directors	Ordinary Meetings	Special Meetings
Prof Sir Christopher Edwards	10/10	1/1
Colin Glass	8/10	0/1
Andrew Havery	9/10	1/1
Prof Richard Kitney	7/10	1/1
Karin Norman	9/10	0/1
Charles Wilson	10/10	1/1

Executive Directors	Ordinary Meetings	Special Meetings
Heather Lawrence, Chief Executive	10/10	1/1
Amanda Pritchard, Deputy Chief Executive (Director of Integrated Service Delivery & Modernisation)*	8/8	1/1
Dr Mike Anderson, Medical Director	10/10	0/1
Lorraine Bewes, Director of Finance & Information	10/10	1/1
Mark Gammage, Interim Deputy Chief Executive**	2/2	n/a
Andrew MacCallum, Director of Nursing	10/10	1/1
Catherine Mooney, Director of Governance & Corporate Affairs ***	10/10	1/1

* On maternity leave since December 2009
** Interim Deputy Chief Executive since December 2009
*** Attends Foundation Trust Board meetings as Company Secretary

Significant commitments of the Trust Chairman

The Chairman is a Senior Research Fellow at Imperial College London, Chairman of the Council of the British Heart Foundation, Chairman of GeothermalPlus and Deputy Chairman of CluffGeothermal. In December 2008 he was appointed as the first Chairman of NHS Medical Education England which provides independent advice to the government on education, training and workforce planning for medicine, dentistry, pharmacy and healthcare sciences.

Board of Directors—Who's Who

Non-Executive Directors

Professor Sir Christopher Edwards, Chairman: Professor Edwards was appointed in November 2007. He was the first Principal of Imperial College School of Medicine from 1995 to 2000 before becoming Vice-Chancellor of the University of Newcastle upon Tyne where he led a major restructuring to make it one of the top universities in the UK. During a distinguished medical and academic career, Professor Edwards has held numerous senior positions including President of the Association of Physicians of Great Britain and Ireland and Chairman of the Council of Heads of Medical Schools. He was knighted in June 2008 and appointed as the first Chairman of NHS Medical Education England in December 2008. He is also Chairman of the Council of the British Heart Foundation. He chairs the Finance & Investment Committee.

Charles Wilson, Vice Chair: Charles was appointed in September 2000. He was reappointed for four years in October 2003. His term ended in October 2007 but the Members' Council (now called the Council of Governors) voted to reappoint him for a further two years until October 2009, and then for a further year, and therefore his term ends in October 2010. He is the Senior Independent Director and Chair of the Assurance Committee. Charles spent 50 years in the newspaper industry, serving as editor of a number of papers including The Times. He retired as Managing Director of the Mirror Group plc.

Colin Glass: Colin was appointed for three years from 1 November 2007, his term ends in October 2010. Colin has nearly 30 years' experience of consumer business, having joined Boots as a graduate trainee and subsequently worked for some of the biggest retailers in the country. During his career Colin has been Managing Director of both Dixons Stores Group and PC World, Chief Executive of the food group Watson and Philip plc, and Chairman of online company PhotoBox Ltd. He founded and is actively involved in a social enterprise business which provides work-related training for underprivileged groups in south east Asia.

Andrew Havery: Andrew was reappointed for three years in November 2007, his term ends in November 2010. He has been a councillor in Westminster since 2002. A Non-Executive Director since December 2003, Andrew is a chartered accountant and worked for KPMG for eight years before becoming a compliance officer to investment banks.

Professor Richard Kitney OBE: Professor Kitney was appointed for four years in May 2006, his term ends in October 2010. He is Professor of Biomedical Systems Engineering and Dean of the Faculty of Engineering at Imperial College. A leading authority on the use of IT in healthcare, Professor Kitney is Chairman and Director of Visbion Ltd.

Karin Norman: Karin was reappointed for three years in September 2009, her term ends in October 2012. A Non-Executive Director since July 2005, she worked in investment banking in London and New York as a fixed income specialist, advising on investments, risk and capital management, and structured finance. She was a Non-Executive Director of the NHS Pensions Agency and is currently a member of the Audit Committee and the Investment Committee for Parkinson's UK, a Trustee of the Nursing and Midwifery Council and Chair of My Generation, a community and youth charity that she co-founded.

Executive Directors

Heather Lawrence OBE, Chief Executive: Heather has almost 20 years' experience at NHS Trust Board level, having served as Chief Executive of Hounslow and Spelthorne Community and Mental Health Trust and North Hertfordshire NHS Trust before being appointed Chief Executive at Chelsea and Westminster in May 2000. Her management experience spans all sectors of healthcare and includes major service change, including the development of innovative services, service re-design, developing an academic department, and closure of services. Heather chairs the North West London Critical Care Network and was NHS Employers' lead negotiator for the three-year pay deal for staff on Agenda for Change. Most recently she was a member of the Government's Nursing and Midwifery Commission through which she and 15 other members advised the Government on the future roles of nurses and midwives.

Heather is a Fellow of the Chartered Institute of Personnel and Development. She was awarded the OBE in the New Year's Honours 2009 list for services to healthcare.

Amanda Pritchard, Director of Integrated Service Delivery & Modernisation (Deputy Chief Executive): Prior to her appointment in September 2006, Amanda worked in the Prime Minister's Delivery Unit. She was previously Acting Director of Strategy & Service Development and General Manager for the Surgery and Anaesthetics & Imaging Directorates at Chelsea and Westminster, and Assistant Director of Critical Care & Ambulatory Services at West Middlesex Hospital. Amanda was an inaugural Health Foundation Leadership Fellow. Amanda has been on maternity leave since December 2009.

Dr Mike Anderson, Medical Director: Dr Anderson was appointed in 2003. Previously he was a Consultant Physician and Gastroenterologist at West Middlesex Hospital where he also held the post of Medical Director. He is an Honorary Clinical Senior Lecturer of Imperial College and continues in active clinical practice as a Consultant Gastroenterologist.

Lorraine Bewes, Director of Finance & Information: Prior to her appointment in May 2003, Lorraine was Director of Performance at University College London Hospitals NHS Foundation Trust and Deputy Director of Finance at Hammersmith Hospitals NHS Trust. She joined the NHS in 1991 following a successful commercial accountancy career, during which she worked at ITN and WH Smith Television Services.

Mark Gammage, Interim Deputy Chief Executive and Director of Human Resources: Mark is providing interim cover during Amanda Pritchard's maternity leave which started in December 2009. He is also the Interim Director of Human Resources. Since 2002 Mark has been Managing Director of Dearden Consulting, a well-established healthcare consultancy firm, and his consultancy work has included working as a Director of HR in a number of different NHS organisations. Mark has also coached a wide range of individuals and worked as an accredited coach with the NHS National Institute for Innovation and Improvement, the Department of Health and others. Mark is a Fellow of the Chartered Institute of Personnel and Development.

Andrew MacCallum, Director of Nursing: Andrew was appointed in August 2003, having previously been Director of Nursing at Queen Mary's Sidcup NHS Trust and Deputy Director of Nursing at Guy's and St Thomas' NHS Trust. Andrew is leaving the Trust at the end of May 2010 to take up a new post as Pro-Vice Chancellor and Dean of Nursing and Human Sciences at Thames Valley University.

Catherine Mooney, Director of Governance & Corporate Affairs: Before being appointed in March 2006, Catherine was Chief Pharmacist at St Mary's NHS Trust for 15 years and was the Clinical Governance Manager at Hammersmith Hospitals NHS Trust from October 2003. She attends Foundation Trust Board of Directors meetings as Company Secretary.

Audit Committee

Membership & Attendance

The Audit Committee is chaired by Andrew Havery, a Non-Executive Director, and includes two other Non-Executive Directors—Karin Norman and Charles Wilson. It met six times in 2009/10—Andrew Havery attended all meetings, Charles Wilson and Karin Norman attended four meetings each.

How the Committee discharges its responsibilities

The Audit Committee assures the Board of Directors that probity and professional judgement are exercised in all financial matters.

It advises the Board on the adequacy and effectiveness of the Trust's systems of internal control and its arrangements for risk management, control and governance processes, and securing economy, efficiency and effectiveness (value for money). It prepares an annual report for the Board.

Policy for safeguarding the external auditors' independence

In so far as the Trust has purchased work from its external auditors outside the audit code in 2009/10, the external auditors' objectivity and independence have been safeguarded.

Responsibility for preparing the annual accounts

The Chief Executive is the Trust's designated Accounting Officer with the duty to prepare the accounts in accordance with the National Health Service Act 2006.


A baby receives treatment on the Neonatal Intensive Care Unit

Nominations Committees

Both the Board of Directors and the Council of Governors have a Nominations Committee:

Nominations Committee of the Council of Governors for the appointment of Non-Executive Directors

The Nominations Committee of the Council of Governors comprises the Chairman of the Foundation Trust (or the Vice Chair when a Chairman is being appointed, unless the Vice Chair is applying for appointment as Chairman, in which case another Non-Executive Director), two elected Governors and one appointed Governor.

Another person nominated by the Nominations Committee is invited to act as an independent assessor to the Nominations Committee of the Council of Governors.

This Nominations Committee identifies appropriate candidates for Non-Executive Director vacancies through a process of open competition which takes account of the policy maintained by the Council of Governors and the skills and experience identified by the Board of Directors.

It makes recommendations about suitable candidates for approval by the Council of Governors.

This Nominations Committee also reviews the policy for the size, structure and composition of Non-Executive Director membership of the Board of Directors. This takes account of relevant Trust strategies from time to time, and not less than every three years, and makes recommendations to the Council of Governors.

There were no meetings of the Nominations Committee of the Council of Governors in the 2009/10 financial year.

Nominations Committee of the Board of Directors for the appointment of Executive Directors

The Nominations Committee of the Board of Directors comprises permanent members who are the Chairman and the Chief Executive (except for consideration of his/her own appointment, reappointment or removal), as well as temporary members drawn from a membership pool of the Board of Directors.

The Board agrees to temporary members joining the Committee for the consideration of each Executive Director vacancy. The temporary members shall be discharged immediately after the selection of the shortlisted candidates.

This Nominations Committee identifies appropriate candidates for Executive Director vacancies through a process of open competition which takes account of an evaluation of the balance of skills, knowledge and experience of the Board and makes recommendations for shortlisted candidates to the Board's Appointments Panel which consists of the Chairman, Chief Executive (except for his/her own appointment) and other Non-Executive Directors.

There were no meetings of the Nominations Committee of the Board of Directors in the 2009/10 financial year.

BBC presenter and journalist Sophie Raworth unveils a plaque to officially open the revamped Assisted Conception Unit in May 2010

Council of Governors

How the Board of Directors and the Council of Governors operate

The Council of Governors represents the interests of the local community—patients, public and staff who are Foundation Trust members—and shares information about key decisions with Foundation Trust members.

The Council of Governors is not responsible for the day-to-day management of the organisation which is the responsibility of the Board of Directors.

Key roles of the Council of Governors are to:

- Appoint or remove the Chairman and other Non-Executive Directors and approve the appointment (by Non-Executive Directors) of the Chief Executive
- Decide the remuneration, allowances and other terms and conditions of office of Non-Executive Directors
- Appoint or remove the Foundation Trust's Financial Auditors
- Review the Trust's constitution and suggest changes
- Review and develop the Trust's Membership Development and Communications Strategy

Composition of the Council of Governors

There are 35 Governors including:

- Chairman (appointed)—also Chairman of the Board of Directors
- 6 Staff (elected)—1 each from 6 staff constituencies
- 8 Public (elected)—2 each from 4 local boroughs
- 10 Patients (elected)—patients treated at the hospital in the last 3 years or their carers
- 10 Nominated Representatives (appointed)—nominated from 10 partnership organisations

The Council of Governors meets quarterly. There were four meetings in 2009/10.

Executive and Non-Executive Directors are invited to attend. Details of their attendance are in the table 'Directors' attendance at Council of Governors meetings 2009/10'. Details of Governors' attendance at meetings are in the table 'Foundation Trust Governors—Who's Who'.

Governors' initial terms of office commenced on the day that the Foundation Trust was licensed, 1 October 2006. Both elected and appointed Governors normally hold office for a period of three years and are eligible for re-election or reappointment at the end of that period. Governors may not hold office for more than nine consecutive years.

Elections held during 2009/10

An election was held in 2009/10 in the Patient constituency. Cass J Cass-Horne, Alan Cleary, Edward Coolen, Susan Maxwell, Wendie McWatters and Taryn Youngstein were elected. Jim Smith was re-elected.

An election was also held in 2009/10 in the constituency Public: Hammersmith & Fulham Area 2—Christine Blewett was re-elected.

An election was also held in 2009/10 in a number of the Staff constituencies. In the constituency Staff: Allied Health Professionals, Scientific & Technical, Lucy Ball was elected. In the constituency Staff: Contracted, Jacinto Jesus was elected. In the constituency Staff: Management, Carol Dale was elected. In the constituency Staff: Medical & Dental, Professor Brian Gazzard was re-elected. In the constituency Staff: Support, Administrative & Clerical, Sinead Jones was elected.

Access to register of Governors' interests

Members of the public can gain access to the register of Governors' interests by making a request to the Foundation Trust Secretary, Chelsea and Westminster Hospital NHS Foundation Trust, 369 Fulham Road, SW10 9NH, via email ftsecretary@chelwest.nhs.uk or on 020 8846 6716.

How the Board has acted to understand the views of Governors and Foundation Trust members

Executive and Non-Executive Directors have attended Council of Governors meetings to gain an understanding of the views of Governors and the membership constituencies they represent.

Governors attended the hospital Open Day in May 2009 to meet Foundation Trust members and discuss the work of the Council. Governors and Foundation Trust members were also invited to attend the Annual Members' Meeting in September 2009 to give their views on the Trust.

Governors were invited to attend a strategy seminar led by the Trust Chief Executive and Chairman in September 2009. Following this seminar, Governors' views were taken into account and the Chief Executive gave a final strategy and business planning presentation to Governors at the Council of Governors meeting in February 2010.

Directors' attendance at Council of Governors meetings 2009/10

Non-Executive Directors	Attendance
Prof Sir Christopher Edwards	4/4
Colin Glass	1/4
Andrew Havery	2/4
Prof Richard Kitney	2/4
Karin Norman	2/4
Charles Wilson	4/4

Executive Directors	Attendance
Heather Lawrence, Chief Executive	4/4
Amanda Pritchard, Deputy Chief Executive (Director of Integrated Service Delivery & Modernisation)*	3/3
Dr Mike Anderson, Medical Director	3/4
Lorraine Bewes, Director of Finance & Information	4/4
Mark Gammage, Interim Deputy Chief Executive**	1/1
Andrew MacCallum, Director of Nursing	4/4
Catherine Mooney, Director of Governance & Corporate Affairs ***	4/4

* On maternity leave since December 2009
** Interim Deputy Chief Executive since December 2009
*** Attends Foundation Trust Board meetings as Company Secretary


Trust Chairman, Professor Sir Christopher Edwards launches the hospital Open Day in May 2010

Foundation Trust Governors—Who's Who

Council of Governors—Who's Who

Name (Constituency/Organisation)	Date elected or appointed	Attendance at Council Meetings 2009/10*
Prof Sir Christopher Edwards (Chairman)	Nov 2007	4/4
Ball, Lucy (Staff — Allied Health Professionals, Scientific & Technical)	Nov 2009	1/2
Balmford, Walter (Patient)	Dec 2007	4/4
Bennett, June (Patient)—left the Council in Feb 2010	Dec 2007	3/4
Birch, Chris (Patient)	May 2007	4/4
Blewett, Christine (Public—Hammersmith & Fulham 2)	Nov 2009	4/4
Bradford, Martin (Public—Hammersmith & Fulham 1)—term of office expired in Nov 2009	Dec 2007	2/2
Browne, Nicky (The Royal Marsden NHS Foundation Trust)	Dec 2006	4/4
Cass-Horne, Cass J (Patient)	Nov 2009	2/2
Cleary, Alan (Patient)	Nov 2009	1/2
Coolen, Edward (Patient)	Nov 2009	1/2
Dale, Carol (Staff—Support, Admin & Clerical)	Nov 2009	1/2
Delamare, Alison (Staff—Contracted)—term of office expired in Mar 2009	Mar 2006	2/2
Finch, Dr David (NHS Wandsworth)	May 2009	2/4
Gazzard, Prof Brian (Staff—Medical & Dental and Deputy Chairman)—Lead Governor	Nov 2009	4/4
Glazebrook, Rosie (NHS Hammersmith and Fulham)	Nov 2009	2/2
James, Cathy (Staff—Support, Admin & Clerical)—term of office expired in Mar 2009	Mar 2006	1/2
Jesus, Jacinto (Staff—Contracted)	Nov 2009	2/2
Jones, Sinead (Staff— Support, Admin and Clerical)—left the Council in Jan 2010	Nov 2009	0/1
King, Jane (Patient)—term of office expired in Oct 2009	Oct 2006	2/2
Lewis, Martin (Public—Westminster 2)	Dec 2007	2/4
Longworth, Catherine (NHS Westminster)	Oct 2006	1/4
Macrae, Dr Duncan (Royal Brompton & Harefield NHS Trust)	Oct 2006	2/4
Maxwell, Susan (Patient)	Nov 2009	2/2
Maze, Prof Mervyn (Imperial College London)—left the Council in Sep 2009	Oct 2006	0/2
McWatters, Wendie (Patient)	Nov 2009	2/2
Mills-Duggan, Ann (Public—Westminster 1)	May 2007	4/4
Moyo, Edgar (NHS Kensington and Chelsea)	Jun 2009	3/3
Nemeth, Cllr Cyril (Westminster City Council)	Nov 2009	1/2
Smith, Jim (Patient)	Nov 2009	4/4
Smith, Sue (Staff—Nursing & Midwifery)	Dec 2007	3/4
Smith, Sue B (Patient)—left the Council in Jun 2009	Dec 2007	0/1
Smith-Gordon, Sandra (Public—Kensington & Chelsea 2)	Oct 2008	4/4
Symons, Mary (Public—Wandsworth 1)	Dec 2007	3/4
Taylor, Cllr Frances (Royal Borough of Kensington and Chelsea)	Oct 2006	3/4
While, Alison (Major Education Provider)	Oct 2009	2/2
Youngstein, Taryn (Patient)	Nov 2009	1/2

* If individuals joined or left the Council of Governors during the financial year, the number of meetings has been adjusted accordingly

Foundation Trust membership

Who can be a member?

- **Patient constituency:** Any patient treated at the hospital in the last three years, or the carer of a patient
- **Public constituency:** Anyone living in the local boroughs of Kensington and Chelsea, Hammersmith and Fulham, City of Westminster, and Wandsworth—each borough is divided into two areas for Council of Governors elections
- **Staff constituency:** Any member of staff—this constituency is divided into six staff groups which are Allied Health Professionals, Scientific & Technical; Contracted; Management; Medical & Dental; Nursing & Midwifery; Support, Administrative & Clerical

How many people are members?

Number of members	31 Mar 2010
Patients	6,010
Public	6,130
Staff	3,046
Total	**15,186**

How are we developing a representative membership?

The Membership Sub-Committee of the Council of Governors develops and reviews the Membership Development and Communications Strategy and the Membership Development Work Plan.

Initiatives to increase membership recruitment and develop a representative membership in 2009/10 included the amalgamation of membership activity with the Patient Advice and Liaison Service (PALS) to create M-PALS which provides the Trust with more opportunities to promote membership.

The M-PALS team supports the promotion of membership by giving membership application leaflets to all visitors to the M-PALS office in the hospital and by sending out membership application leaflets with all letters responding to comments received by the M-PALS service.

Other initiatives in 2009/10 included:

- Membership recruitment campaigns in advance of the Annual Members' Meeting and the Open Day
- Development of a new membership application leaflet including an Easyread version for people with a learning disability
- Use of the Trust's new community mobile health clinic to undertake health screening and recruit new Foundation Trust members at Chelsea Football Club and other community venues

Analysis of the membership database by age, gender and ethnicity to ensure that it is representative of the communities we serve has identified three particular areas for development:

- Low penetration in the Public: Wandsworth Area 1 constituency
- Significantly lower membership in the under-40 age group
- Lower membership in Black and Asian ethnic groups

In 2010/11 the Trust aims to maintain the current level of both public and patient members. An 'opt-out' system for staff means that all staff are automatically members unless they choose to opt out of membership and therefore proactive recruitment of staff members is not necessary.

Council of Governors' representatives and Foundation Trust members were invited to attend the Annual Members' Meeting in September 2009 to give their views on the Trust.

Get in touch

Members who wish to communicate with their representatives on the Council of Governors or Executive Directors should contact the Foundation Trust Secretary, Chelsea and Westminster Hospital NHS Foundation Trust, 369 Fulham Road, SW10 9NH, via email ftsecretary@chelwest.nhs.uk or on 020 8846 6716.

Hospital volunteers on the Welcome Desk at this year's Chelsea and Westminster Open Day which was sponsored by the Council of Governors

Statutory Information

Directors

The Trust has a Board of Directors including the Chairman, five other Non-Executive Directors and five Executive Directors.

Non-Executive Directors

The Chairman is Professor Sir Christopher Edwards.

The five other Non-Executive Directors are Colin Glass, Andrew Havery, Professor Richard Kitney, Karin Norman and Charles Wilson.

Charles Wilson is the Senior Independent Director.

Executive Directors

Executive Directors are Heather Lawrence (Chief Executive), Dr Mike Anderson (Medical Director), Lorraine Bewes (Director of Finance & Information), Andrew MacCallum (Director of Nursing) and Amanda Pritchard (Deputy Chief Executive/ Director of Service Integration & Modernisation—maternity leave since December 2009). Mark Gammage has been the Interim Deputy Chief Executive since December 2009 while Amanda Pritchard is on maternity leave. Catherine Mooney (Director of Governance & Corporate Affairs) attends Board meetings as Company Secretary.

Brief history of the Trust

Chelsea and Westminster Hospital opened in May 1993 on the former site of St Stephen's Hospital. It replaced five hospitals—St Stephen's, St Mary Abbots, Westminster Children's, Westminster and West London.

Chelsea and Westminster Hospital NHS Foundation Trust was founded on 1 October 2006 under the Health and Social Care (Community Health and Standards) Act 2003.

Environmental matters

The Trust pledged to reduce its carbon footprint by joining the Carbon Trust's NHS Carbon Management programme in May 2007. All staff are encouraged to help cut carbon emissions and reduce energy bills by taking simple steps to be more energy efficient. See page 55 for more information on sustainability/climate change.

Financial information

Disclosure of audit information

So far as the Directors are aware, there is no relevant audit information of which the auditors are unaware.

The Directors have taken all steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Better Payment Practice Code

The Better Payment Practice Code requires the Trust to pay all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later, unless other payment terms have been agreed with the supplier.

The Trust's compliance with the Code is set out in the Notes to the Accounts.

TV presenter Chris Hollins (left) and his father, ex-Chelsea FC legend John Hollins at the official launch of the new Chelsea and Westminster Hospital community health clinic in February 2010 with Sian Nelson (Membership & Engagement Manager) and Heather Lawrence (Chief Executive)

Remuneration Report

Remuneration Committee

The Remuneration Committee is a Standing Committee of the Board of Directors which is appointed in accordance with the constitution of the Trust to determine the remuneration, allowances, pensions and gratuities or terms of service of the Executive Directors and rates for the reimbursement of travelling and other costs and expenses incurred by Directors.

The Board of Directors has delegated responsibility for agreeing remuneration, allowances, pensions and gratuities or terms of service for the Secretary and other Senior Managers. The Remuneration Committee does not determine the terms and conditions of office of the Chairman and Non-Executive Directors. These are decided by the Council of Governors at a General Meeting.

The membership of the Remuneration Committee includes the Trust Chairman, Professor Sir Christopher Edwards, and five Non-Executive Directors—Colin Glass, Andrew Havery, Professor Richard Kitney, Karin Norman and Charles Wilson.

The Remuneration Committee met in April 2010. Professor Sir Christopher Edwards, Andrew Havery and Karin Norman were in attendance. Colin Glass, Professor Richard Kitney and Charles Wilson were absent.

The meeting was attended by the Chief Executive, Heather Lawrence, and the Interim Director of Human Resources, Mark Gammage, for the purpose of providing advice or services to the Committee that materially assist the Committee in the consideration of the matters before them, other than the consideration of their own remuneration, allowances, pensions and gratuities or terms of service.

The Committee agreed to implement the national pay inflation award of 2.25% for staff on Agenda for Change contracts, and to support national recommendations for pay inflation increases for junior doctors.

In line with national recommendations, no pay inflation award was given to consultant medical staff.

The Committee also agreed that, in light of the current economic position, Executive Directors would receive no pay inflation increase.

In order to assess whether performance conditions were met for those officers under the remit of the Committee, appraisals are conducted regularly and progress is assessed against personal and corporate objectives, long and short term.

Remuneration consists mainly of salaries and pension benefits in the form of contributions to the NHS Pension Fund which are not subject to performance conditions. Where performance bonuses are considered in exceptional circumstances, these are limited to 20% of the total salary. No bonuses were awarded in the year under review.

For a breakdown of salary and pension entitlements of senior managers, please see page 77.

Heather Lawrence

Heather Lawrence OBE
Chief Executive (on behalf of the Board)
27 May 2010

Burns patient Katie Piper, pictured with her surgeon Mr Mohammad Jawad—her recovery from horrific acid burns was the subject of a BAFTA-nominated Channel 4 documentary that highlighted the expertise of staff at Chelsea and Westminster

Sustainability/climate change

Commentary

The NHS has a carbon footprint of 18 million tonnes of CO_2 per year and has made a commitment to reducing this in line with government targets.

Chelsea and Westminster Hospital NHS Foundation Trust is committed to playing its part in this overall reduction both as a good corporate citizen and for sound financial reasons.

The Trust has appointed a Board Director to take the lead on sustainability and has recently produced a Sustainable Development Management Plan to support the work to reduce our carbon footprint.

A Sustainable Development Committee has been established to lead on the implementation of the Sustainable Development Management Plan. A number of sub-groups have been set up to work on specific areas of carbon reduction strategy.

To support and enhance the Sustainable Development Management Plan, the Trust has signed up to the Good Corporate Citizen Assessment Scheme.

The initial assessment has identified a number of areas to focus on.

Summary performance

The Trust achieved an overall reduction in energy consumption in 2009/10 of 6.5% compared to the previous year. The total expenditure on all utilities fell by 24% compared with 2008/09 largely as a result of falls in gas and electricity tariffs—see table below for details.

Future priorities and targets

The Trust will be required to register as a participant in the Carbon Reduction Commitment (CRC) by September 2010. As part of the early action metrics for CRC we will be completing a programme to install automatic meter reading and will be working to obtain the Carbon Trust Standard.

The Trust is looking to install a combined heat and power plant which will significantly reduce the Trust's total energy consumption.

The Trust will work to improve its overall rating for the Corporate Good Citizen Assessment Scheme with the intention of achieving at least the London average by March 2011.

The Trust has recently introduced new recycling bins and will be looking to increase recycling rates in 2010/11 from their current level to 40% of all waste.

Area		Non-financial data (applicable metric) 2008/09	Non-financial data (applicable metric) 2009/10		Financial data 2008/09 (£000)	Financial data 2009/10 (£000)
Waste minimisation and management	**Waste produced (tonnes)**	1,360	**1,390**	**Expenditure on waste disposal**	407	**496**
Finite resources	**Water (tonnes)**	184,213	**192,953**	**Water**	254	**282**
	Electricity (kWh)	24,048,300	**22,651,900**	**Electricity**	2,514	**1,846**
	Gas (kWh)	28,452,642	**26,434,984**	**Gas**	883	**632**

Equality & diversity

Commentary

Statement of approach to equality & diversity

The Trust's Deputy Chief Executive is the Executive lead for equality and diversity and Chair of the Equality & Diversity Steering Group which leads the Trust's work on addressing equality and diversity issues in the workforce and service provision for patients. The Trust also employs a full-time Equality & Diversity Manager.

In order to maintain progress with the equality and diversity agenda, the Group has refreshed its terms of reference and its membership to reflect the Trust's organisational restructure which came into effect on 1 April 2010.

The Equality & Diversity Steering Group monitors performance against key internal targets such as training or Equality Impact Assessments and progress of the Single Equality Scheme (SES).

Statement of compliance with publication duties

The Equality Bill received Royal Assent in April 2010 and formally become the Equality Act 2010. In anticipation of the Bill becoming an Act, the Equality & Diversity Manager developed a draft SES and action plan which was consulted upon with staff, equality staff networks, the Council of Governors, and external groups and charities such as Action Disability Kensington and Chelsea.

The Equality & Diversity Manager and a group of volunteers participated in the hospital Open Day in May 2009 to seek views from members of the public on the proposed SES and action plan. The final SES and action plan was approved by the Trust Board of Directors in October 2009.

The provisions in the Act will come into force in stages. Existing legislation has been replaced with a single Act which will form the basis of straightforward practical guidance for

employers, service providers and public bodies covering duties on age, sexual orientation, religion or belief as well as the existing duties on race, disability and gender. The overriding duties to promote equality of opportunity and eliminate harassment will remain the same. Prior to October 2009 the Trust had three separate statutory equality schemes for race, disability and gender.

The Trust produces an equality and diversity annual report that is submitted to the Trust Board of Directors. It includes analysis of workforce monitoring as well as a report on the progress of the SES. Equality Impact Assessments are also published.

Action plans and timeframe to address any shortfalls

The SES was implemented before the Equality Bill received Royal Assent. In 2010/11 the Equality & Diversity Manager will review the Equality Act to ensure that the Trust's SES complies with legislation. The action plan will then be amended to reflect any changes, if required. Key objectives from the action plan will be reviewed and, if they have not been completed in the specified timeframe, an amended timeframe will be agreed to ensure the objective is met.

The equality and diversity pages on the Trust website pages are currently being updated. All completed Equality Impact Assessments will be uploaded on the website as a matter of priority.

Summary of performance—workforce statistics

Trust workforce profile 2009/10

The Trust's ethnic profile compared with the local population shows that Black and Minority Ethnic (BME) staff are well represented, particularly in the clinical directorates. When comparing the ethnic profile of the Trust's workforce with the ethnic profile of London, we employ more staff from White Irish, Black African, Black Caribbean, Chinese and 'Any Other' ethnic or 'Mixed' backgrounds. In contrast we employ fewer staff from White British, Bangladeshi, Pakistani and 'Any Other' Black backgrounds. The ethnic composition of our workforce has marginally changed since last year.

The Trust has a younger workforce than other Foundation Trusts. The largest group of staff come from the 30–34 age bracket which amounts to almost 20% of the workforce. Within this age bracket most staff are employed in Nursing & Midwifery or Medical & Dental staff groups.

According to our Electronic Staff Record (ESR) database, the Trust workforce is 75% female and 25% male. No transgender staff are noted by the ESR database. This has not changed for the last three years and reflects the gender split across the NHS.

Only 0.67% of staff have declared that they have a disability but recent staff survey results indicated that we have a higher percentage of staff with a declared disability than indicated by the ESR database. The Trust is actively exploring ways to encourage staff to report their disability status so that we can ensure we are meeting their needs accordingly.

Trust membership profile 2009/10

The Membership Sub-Committee of the Council of Governors develops and reviews the Membership Development and Communications Strategy and the Membership Development Work Plan including initiatives to develop a representative membership.

Analysis of the membership database by age, gender and ethnicity to ensure that it is representative of the communities we serve has identified three particular areas for development:

- Low penetration in the Public: Wandsworth Area 1 constituency
- Significantly lower membership in the under-40 age group
- Lower membership in Black and Asian ethnic groups

Priorities and targets going forward

Statement of key priority areas

These key priority areas from the action plan will provide a focus for the Trust to concentrate its efforts on addressing equality and diversity issues over the next three years:

- Leadership, corporate commitment and governance
- Equality Impact Assessments
- Partnership working, consultation and involvement
- Accessibility and communications
- Workforce and training
- Commissioning and procurement
- Monitoring data, reporting and publishing
- Complaints

Performance against key priority areas

Performance will be monitored periodically by the Equality & Diversity Steering Group. Internal Trust targets for training and Equality Impact Assessments will also be monitored by the Equality & Diversity Steering Group.

Monitoring arrangements

The requirement for equality monitoring is enshrined in law and is assessed annually by the Care Quality Commission. In addition, NHS trusts have to demonstrate their compliance with equality and diversity standards set by the Care Quality Commission.

The purpose of collecting equality data is to enable organisations to ensure that they are not intentionally or unintentionally discriminating against any particular group of people and to enable them to develop appropriate and equitable services for service users and career development opportunities for staff.

We have included information in our SES about all the diversity strands. Each year we will produce a report detailing the progress we have made.

We will publish the results of our Equality Impact Assessments and any action plans or improvements we will be making. This will ensure that we share best practice in all our equality work.

Each year we will produce an annual report for the Trust Board that includes workforce monitoring data as well as a report on the progress of the SES. The Trust's Equality & Diversity Steering Group will monitor the progress of the SES.

Future priorities and how they will be measured

During 2010/11, a priority is for 33% of all staff to attend equality and diversity training. All departments will be required to submit an action plan for completing Equality Impact Assessments in 2010/11. The Equality & Diversity Steering Group will monitor both targets.

Summary of Trust workforce and Foundation Trust membership diversity data

Workforce	Staff 2008/09	% 2008/09	Staff 2009/10	% 2009/10
Age				
<20	9	0.30%	4	0.13%
20-24	159	5.67%	156	5.25%
25-29	516	18.40%	550	18.51%
30-34	553	19.00%	556	18.71%
35-39	443	15.79%	486	16.36%
40-44	380	13.55%	380	12.79%
45-49	304	10.83%	320	10.77%
50-54	194	6.92%	249	8.38%
55-59	147	5.24%	142	4.78%
60-64	80	2.85%	98	3.30%
65-69	14	0.50%	21	0.71%
70+	6	0.21%	9	0.30%
Ethnicity				
White British	1,234	44.0%	1,312	44.2%
White Irish	122	4.3%	118	4.0%
White Other	335	11.9%	368	12.4%
White & Black Caribbean	24	0.9%	26	0.9%
White & Black African	9	0.3%	12	0.4%
White & Asian	23	0.8%	18	0.6%
Mixed—Other	37	1.3%	36	1.2%
Asian/Asian British Indian	149	5.3%	165	5.6%
Asian/Asian British Pakistani	32	1.1%	25	0.8%
Asian/Asian British Bangladeshi	9	0.3%	12	0.4%
Asian/Asian British—Other	162	5.8%	170	5.7%
Black/Black British—Caribbean	177	6.3%	177	6.0%
Black/Black British—African	222	7.9%	246	8.3%
Black/Black British—Other	28	1.0%	32	1.1%
Other—Chinese	49	1.7%	55	1.9%
Other—Any Other Ethnic Group	112	4.0%	119	4.0%
Undisclosed	81	2.9%	80	2.7%
Gender				
Female	2,090	75%	2,229	75%
Male	715	25%	742	25%
Disability				
Declared disability	9	0.03%	20	0.67%

Membership	Membership 2008/09	% 2008/09	Membership 2009/10	% 2009/10
Age				
0-16	2	0.02%	2	0.02%
17-21	130	1.04%	150	1.21%
22+	8,443	67.50%	8,551	69.00%
Unknown	3,933	31.44%	3,671	29.67%
Ethnicity				
White	6,994	55.92%	7,021	56.73%
Mixed	327	2.61%	387	3.13%
Asian or Asian British	608	4.86%	641	5.18%
Black or Black British	473	3.78%	541	4.37%
Other	442	3.53%	445	3.60%
Unknown	3,664	29.29%	3,341	27.00%
Gender				
Female	7,314	58.47%	5,108	41.27%
Male	5,116	40.90%	4,300	34.74%
Unknown	78	0.62%	2,968	23.98%
Disability				
Declared disability	not recorded	not recorded	not recorded	not recorded

Staff survey

Commentary

The Trust is committed to keeping staff fully informed about everything that has an impact on their working lives at Chelsea and Westminster by providing them with information, consulting with them on key decisions, and listening to their concerns.

A range of initiatives are in place to provide staff with information on matters of concern to them, consult staff or their representatives so that their views are taken into account in making decisions that are likely to affect their interests, encourage the involvement of staff in the Trust's performance, raise staff awareness of financial and economic factors affecting the Trust's performance, and monitor and learn from staff feedback:

- Executive Directors meet Staffside representatives at monthly meetings of the Joint Management and Trade Union Consultative Committee (JMTUC) and the Director of Human Resources meets with the Staffside Chair on a fortnightly basis
- The Council of Governors, which includes elected staff representatives, meets quarterly
- Communication with staff includes a monthly staff magazine, a monthly face-to-face Team Briefing with Executive Directors which is disseminated through the line management structure to all staff, and a Daily Noticeboard email bulletin
- The Chief Executive holds ad hoc face-to-face staff briefings to engage staff with important strategic issues such as the redevelopment of the hospital and the need to make 10% cost savings in 2010/11 without compromising quality of care
- Executive Directors are allocated specific areas of the Trust on a monthly basis and are expected to visit these areas, engage with staff and feedback any issues to the Executive team

The Trust was ranked among the top 20% of trusts in the 2009 NHS staff survey for staff engagement and 37% of staff reported good communication between senior management and staff, which was the best performance of any Association of UK University Hospitals (AUKUH) Trust.

Summary of performance—results from the staff survey 2009

65% of staff completed the NHS staff survey 2009 (compared with 61% in 2008). This rate was the highest among Acute Trusts in London, the highest among AUKUH Trusts, and the second highest among all Acute Trusts nationally.

The survey was structured around the four national pledges to staff given in the NHS Constitution and two additional themes around staff satisfaction and equality and diversity. These pledges and themes are reported under 40 key findings (KFs). There were 36 existing KFs and four new KFs for the 2009 staff survey.

For the first time this year the Care Quality Commission calculated a 'Staff Engagement Score', which includes staff's perceived ability to contribute to improvements at work, their willingness to recommend the Trust as a place to work or receive treatment, and the extent to which staff feel motivated and engaged with their work.

The Trust's staff engagement score places us in the top 20% of acute Trusts in the country.

The Trust improved or maintained its performance for 83% of the 36 key KFs.

The key area of improvement for this Trust was around Staff Pledge 2 which asks about appraisals, personal development, access to training and line management support.

All six KFs covered by this pledge saw an improvement on the Trust's 2008 results, and were higher than the national average for acute Trusts—five of the six KFs were in the highest (best) 20% of acute Trusts in the country.

Staff responding that they had had an appraisal within the previous 12 months increased by 18% on 2008, up to 76%.

The Trust also improved its performance on KFs including:

- Staff satisfaction with the quality of work/patient care they deliver
- Trust commitment to work-life balance
- Perceptions of effective action from the Trust towards violence and harassment
- Staff understanding where their role fits in

Areas of concern for the Trust focused on four KFs because our responses were lower than last year's survey and lower than the national average:

- KF10: % of staff using flexible working options
- KF20: % of staff saying hand washing materials are always available
- KF39: % of staff believing the Trust provides equal opportunities for career progression or promotion
- KF40: % of staff experiencing discrimination at work in the last 12 months

The results of the survey have been published and action plans to address these areas of concern and improve on other key findings will be produced by departments across the Trust.

NHS Staff Survey response rate 2009 & job satisfaction KF

Staff Survey	2008/09 Trust	2008/09 National Average	2009/10 Trust	2009/10 National Average	Trust improvement/ deterioration
Response rate	61%	55%	65%	55%	+4.0%
KF34:Staff job satisfaction (scored from 1–5, with 1 representing very unsatisfied and 5 representing very satisfied staff)	3.47	3.45	3.51	3.47	+0.4

Top and Bottom Ranking Scores

These KF scores show where the Trust compares most favourably with other acute trusts in England (top) and least favourably with other acute trusts in England (bottom).

Top 4 ranking score	2008/09 Trust	2008/09 National Average	2009/10 Trust	2009/10 National Average	Trust improvement/ deterioration
KF31: % of staff reporting good communication between senior management and staff	32%	25%	37%	26%	+4%
KF32: % of staff agreeing that they understood their role and where it fits in	55%	45%	62%	47%	+7%
K11: % of staff feeling there are good opportunities to develop their potential at work	48%	42%	51%	42%	+3%
KF36: % of staff who would recommend the Trust as a place to work or receive treatment	n/a	n/a	76%	70%	new measure in 2010

Bottom 4 ranking score	2008/09 Trust	2008/09 National Average	2009/10 Trust	2009/10 National Average	Trust improvement/ deterioration
KF10: % of staff using flexible working options	63%	71%	61%	70%	-2%
KF9: % of staff working extra hours (the lower score the better)	75%	68%	74%	65%	+1%
KF20: % of staff saying hand washing materials are always available	56%	69%	55%	69%	-1%
KF17: % of staff receiving health and safety training in last 12 months	55%	76%	61%	78%	+6%

Future priorities and targets

The Trust plans to engage with staff and improve staff feedback further in accordance with the NHS Constitution.

We carried out an internal communications survey in March 2010:

- 75% of staff said they found it 'Very easy' or 'Fairly easy' to get information about what is going on in the Trust
- 96% of staff rated the monthly staff magazine *Trust News* as 'Excellent' or 'Good'
- 91% of staff said the Daily Noticeboard email bulletin was 'Just right' in terms of the information it provides to staff each day
- 73% of staff said their manager discussed the monthly Team Briefing with them 'Every month' or 'Sometimes'

However, only 49% of staff said their manager discussed Team Briefing with them every month.

The Trust plans to undertake a detailed audit of Team Briefing to pinpoint areas in which line managers are not using it as intended.

The Trust will also be establishing 'employee circles' to involve staff in key decisions in the Trust.

The main mechanism in place to monitor performance against the key findings of the staff survey is the Trust's staff survey action plan which will focus on addressing areas of concern from this year's survey and building on areas of strength.

Each department and directorate will have their own plan to work on to address 'local' issues. Progress will be reported through the Trust's established communication systems.

Regulatory ratings

Commentary

Explanation of ratings

- **Financial risk rating**—when assessing financial risk, the Foundation Trust regulator Monitor assigns a risk rating using a scorecard which compares key financial metrics on a consistent basis across all NHS foundation trusts.

  The risk rating is intended to reflect the likelihood of a financial breach of the authorisation.

  The financial indicators used to derive the financial risk rating incorporate five individual ratings which are each rated 1 (high risk) to 5 (low risk)

- **Governance risk rating**—Monitor's assessment of governance risk is based predominantly on NHS foundation trusts' plans for ensuring compliance with the terms of their authorisation but will also reflect historic performance where this may be indicative of future risk.

  Monitor considers eight elements when assessing the governance risk rating—legality of constitution, growing a representative membership, appropriate Board roles and structures, service performance, clinical quality and patient safety, effective risk and performance management, co-operation with NHS bodies and local authorities, and provision of mandatory services.

  Monitor rates governance risk using a graduated system of green, amber/green, amber/red and red, where green indicates low risk and red indicates high risk.

Summary of performance

In 2009/10 the Trust was rated green for both the governance risk rating and the mandatory services rating in each quarter.

The financial risk rating was planned at 4 but varied from plan in the second quarter when it was rated 3 although the overall rating for 2009/10 was 4.

This performance was in line with expectation in the annual plan.

Performance in 2008/09 was also green for both the governance risk rating and the mandatory services ratings and 5 for the financial risk rating.

Financial risk rating performance

The Trust planned to achieve an overall financial risk rating of 4 at the end of each quarter of 2009/10, on the cumulative position. This was achieved in the first, third and fourth quarters, resulting in an overall rating of 4 for the financial year. In the third quarter the rating reduced to 3 overall—the reasons for this are discussed below.

The overall financial risk rating reflects the weighted average of five individual ratings—two of the five ratings were below plan, Achievement of Plan and Return on Assets.

The Achievement of Plan rating assesses EBITDA achieved against EBITDA planned and this was 83% at the end of the second quarter which is a 3 rating.

This position recovered in the third quarter and at the end of the fourth quarter EBITDA achieved was 89% which provides a 4 rating.

The second rating below plan was Return on Assets which achieved a 3 rating in the third quarter when a 4 rating was planned. This was a consequence of lower EBITDA resulting in a lower surplus. The Trust achieved a 5.0% return on assets in the third quarter when it had planned for a 5.7% return.

This position recovered in the fourth quarter in line with the increase in EBITDA and the return on assets achieved at year end was 5.4% (a rating of 4).

Table of analysis

2008/09	Annual Plan	Q1	Q2	Q3	Q4
Financial risk rating	5	5	5	5	5
Governance risk rating	GREEN	GREEN	GREEN	GREEN	GREEN
Mandatory services	GREEN	GREEN	GREEN	GREEN	GREEN

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

Public interest disclosures

Action to inform, involve & consult with staff

See the 'Staff survey' section on page 58 for details.

Policies in relation to equal opportunities

The Trust aims to be an employer of choice for all. We have an Equality & Diversity Policy to ensure there is no direct or indirect discrimination and to build a workforce whose diversity reflects the community we serve.

The Trust has joined the Stonewall Workplace Diversity Champions Programme, established a network of staff groups including a Disability Action Group, a Black and Minority Ethnic Staff Network, and a Gay, Lesbian, Bisexual and Transgender (GLBT) Staff Network.

The Trust is a recognised '2 Ticks' employer. This status is awarded by Jobcentre Plus to employers that have made commitments to employ and develop the abilities of disabled staff.

Policies in relation to disabled staff

Policies for giving full and fair consideration to applications for employment from disabled people

The Trust has an Equality & Diversity Policy and a Recruitment and Selection Policy and Procedure so that applications by disabled candidates receive full and fair consideration. Specific support for Trust staff and candidates is provided by recruitment training days which are compulsory for staff who participate in recruitment panels, as well as a policy for the recruitment and retention of staff with disabilities.

Policies for continuing the employment of, and arranging appropriate training for, staff who have become disabled

Disabled staff, managers, Human Resources and Occupational Health staff advise on adjustments to support disabled staff including adjustments to job roles, working hours and environment, and provide additional training in line with the policy for the recruitment and retention of staff with disabilities.

Policies for training, career development and promotion of disabled staff

Staff should have regular performance development reviews and training needs support through the Knowledge and Skills Framework.

Health & Safety performance

Due to improved levels of reporting, the number of incidents reported to the Health & Safety Executive increased from nine in 2008/09 to 36 in 2009/10.

Occupational Health performance

The Occupational Health department provides services including fitness for work assessments, screening for infectious and communicable diseases, support for staff and managers in relation to sickness absence and rehabilitation, and moving and handling training.

In 2009/10, the department led the Trust's Pandemic Flu Staff Protection Programme which included ensuring that all staff were kept informed about the best ways in which to protect themselves and their patients.

Approximately 1,756 staff were vaccinated by the Occupational Health team and 25 senior nurses which meant the Trust was among the best prepared nationally. A further 660 staff underwent 'fit testing' for high protection respirator facemasks in preparation for a possible pandemic, in line with Department of Health guidance.

Counter-Fraud policies & procedures

The Trust has a Counter-Fraud Policy for dealing with suspected fraud and corruption, and other illegal acts involving dishonesty or damage to property.

Nominated staff who Trust staff can contact confidentially if they suspect a fraudulent act are the Director of Finance & Information and the Local Counter Fraud Specialist (LCFS).

Sickness absence data

The annual sickness absence level in the Trust in 2009/10 was 3.48%.

Members of the Creating Excellence Together Network Group which supports Black and Minority Ethnic (BME) staff

Finance

Statement of Accounting Officer's responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of Chelsea and Westminster Hospital NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the Accounting Officer Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

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

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements
- prepare the financial statements on a going concern basis

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable her to ensure that the accounts comply with requirements outlined in the above mentioned Act.

The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Heather Lawrence

Heather Lawrence OBE
Chief Executive and Accounting Officer
27 May 2010

Statement on Internal Control

Statement on internal control for the period 1 April 2009 to 31 March 2010

1. Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me.

I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

2. Purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Chelsea and Westminster Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in Chelsea and Westminster Hospital NHS Foundation Trust for the year ended 31 March 2010 and up until the date of approval of the annual report and accounts.

3. Capacity to handle risk

The Trust has a risk management strategy and operational policies approved by the Trust Board. The accountability for clinical and corporate governance, including risk management, rests with the Director of Governance & Corporate Affairs.

All Directors working in the Trust take responsibility for risk mitigation within their areas of work and practice, in line with the management and accountability arrangements in the Trust. The delivery of risk management occurs through management action and accountability arrangements and

risk mitigation is monitored through the Trust's Operational Risk Management Committee and in addition other committees as appropriate eg the Health and Safety and Fire Committee, the Capital Programme Board and the Information Management and Technology Committee. The Operational Risk Management Committee reports to the Trust Executive for Clinical Governance and also provides reports to the Assurance Committee, which reports to the Board.

The risk management team within the Trust provides support to directorates and departments on all aspects of effective risk assessment and management. Directorates have an identified senior lead for risk management. The Trust risk management team maintain the Trust's incident/risk reporting system and risk and incident review registers. The team also has a vital role in training, the dissemination of good practice and lessons learned from incidents or near misses. This is also achieved through sharing incidents at relevant committees eg Operational Risk Management Committee and Trust Executive for Clinical Governance.

Risk management training is given to staff on induction and regular training opportunities are provided within the hospital to staff at all levels, including root cause analysis training.

The Trust maintained Level 2 of the Clinical Negligence Scheme for Trusts (CNST) maternity standards following the assessment in February 2010. The Trust achieved Level 2 in the general NHS Litigation Authority Risk Management Standards in December 2008.

4. The risk and control framework

The risk management strategy identifies the key elements to managing risk. This includes reactive risk management through analysis of incidents, identification of trends, investigations of serious incidents and identification of action plans to reduce risk. These actions are monitored through the incident monitoring database. Risk is identified in the Trust proactively in a number of different ways. Directorates and departments undertake an annual comprehensive risk review using a risk assessment tool. Key gaps in meeting risks are identified and action plans developed. Risks are also identified on an ad hoc basis and evaluated using the Trust risk assessment form. This captures risk information for clinical and non-clinical risks and supports risk evaluation and action planning. Risks may also be identified from incidents, complaints and claims.

A colour coded risk matrix is used to rate risks. Risk assessments are peer reviewed to include an assessment of the risk rating to ensure validity. All risks are entered into the centrally held risk register, which is managed by the corporate risk team. Risks that are red or orange are reviewed at the Operational Risk Management Committee and if appropriate by other committees eg those with capital implications are reviewed at the Capital Programme Board. Current Assurance Framework risks are monitored by the Board. Risks from previous objectives continue to be monitored through the executive team. Leads for risk areas provide updates either as risks are mitigated or by default every 3 months. Risk assessments and the directorate risk register are part of the quarterly Clinical Governance Reports which are reviewed by the directorates. Risks that are red are notified to the Trust Board and these are monitored quarterly.

Risk management is embedded in the activity of the organisation in a number of ways. The strategy describes local risk management processes which reflect the overall strategy of the Trust. In addition directorates and departments are required to identify risks associated with objectives; risk identification is part of the business planning template; and risk identification is included in application forms for capital expenditure. The capital plan is regularly compared with the risk register to ensure significant risks requiring funding are prioritised.

Risks which may prevent the Trust from achieving its corporate objectives are identified during the development of the Trust's Assurance Framework.

The Trust manages its risks to data security through a number of different approaches. The Trust has a Board level Senior Information Risk Owner (SIRO). The SIRO chairs an Information Governance Committee (IGC) which is responsible for setting the framework for information governance standards in the Trust and ensuring delivery of action plans to improve compliance. A key part of the IGC's work is to review compliance against the Information Governance Toolkit and to ensure the evidence is externally assured through audit. The key strands of the Trust's management of risk to data security are:

- the development of appropriate information governance policies and staff procedures eg the Trust has an approved Information Risk policy which provides the framework for managing information risk in conjunction with an Information Governance Strategy and Policy, Information Security Policy and overall Risk Management Policy and Strategy

- developing a range of information governance training packages and literature, suitable to the needs of different staff groups and mandating this annually. The Trust has focused on areas of particular sensitivity eg HIV and sexual health services

- ensuring the Trust's IT systems are physically secure and have sufficient password protection and firewalls to prevent harm from malware or external hacking—this also includes provision of encrypted portable devices and provision of email encryption facilities

While the Trust has been externally assessed as green on its Information Governance toolkit, it has identified a few risk areas to improve as follows:

- Risk that not all staff complete their training and lack of assurance on staff competency in information governance awareness; this particularly relates to potential for lack of awareness of some staff and patients of the procedures to safeguard patient confidentiality and assure data protection

- Risk that not all flows of person identifiable information have been mapped

- Risk that the structure for managing information assets has not been fully embedded within the organisation to enable proactive risk assessment within each department

The Trust's plans for mitigating the above risks are:

- to conduct awareness surveys amongst staff and patients about the use of personal information

- to complete a comprehensive information flow mapping to analyse the type of information accessed by staff and their level of authorisation. The Trust's strategy is to implement an Electronic Document Management System which will help to address this risk

- to identify Information Asset Owners and Information Asset Administrators for each system and train them in their responsibilities for proactive information risk assessment

The outcomes of the above risk mitigation will be assessed as part of the Information Governance toolkit assessment for 2010/11 where all these areas will be targeted to improve from their current Level 2 status to Level 3.

The Trust reported a near miss to the Information Commissioner's Office where following the theft of two laptops from the Trust's premises, it was found that one was not encrypted. Whilst no loss of sensitive data occurred on this occasion, the Trust treated this as a serious incident with a full investigation and report to the Information Commissioner's Office and the Board. As a result, actions in relation to improving the physical security, completion of a full audit of the encryption of laptops and information governance training are being followed up by the Board.

The Audit Committee now receives a regular update on information governance and will assure the Board through the reports to the Board.

The lead PCT is involved in risks which affect them through negotiation on the contract. In addition there is liaison and partnership work with relevant bodies on risks which affect them or which they can mitigate eg ISS Mediclean for facilities management, Olympic South Limited for transport, and Norland for estates, the local safeguarding children's board for children's issues, and various organisations for safeguarding vulnerable adults. The Trust also works with local agencies on emergency and business continuity planning.

The Foundation Trust is fully compliant with the core Standards for Better Health.

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

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

The Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place. They need to more fully take account of emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Board received an account of the steps which have been put in place to ensure that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data. This was informed by a review of the standards for better data quality contained in the Audit Commission publication '*Figures you can trust: A briefing on data quality in the NHS 2009*'. This covers governance and leadership, policies, systems and processes, people and skills and data use and reporting. The Board also received a report of the quality assurance processes in place to prepare the report including external assurances where relevant.

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

The development and reporting of patient level costing and service level reporting ensures that the Board is aware of relative profitability and efficiency. This information is used proactively to identify opportunities for improving efficiency and profitability for each service. Service line reports have been developed to improve access to drill down reports to investigate cost variation.

Monthly finance and performance reports are provided to the Board. The Trust has exceeded the target net surplus. A new divisional structure to strengthen clinical accountability for resource use has been developed for implementation next year.

It is within Internal Audit's remit to make recommendations on the effective use of resources and they have undertaken a review of cost improvement and procurement processes.

6. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board ensures the effectiveness of the system of internal control through clear accountability arrangements.

The Audit Committee is a formal sub-committee of the Board and is accountable to the Board for reviewing the establishment and maintenance of an effective system of internal control and risk management. The committee meets at least 5 times per year. The Audit Committee approves the annual audit plans for internal and external audit activities and ensures that recommendations to improve weaknesses in control arising from audits are actioned by executive management.

The Audit Committee ensures the robustness of the underlying process used in developing the Assurance Framework. The Board monitors the Assurance Framework and objectives quarterly, ensuring actions to address gaps in control and gaps in assurance are progressed.

The Finance and Investment Committee conducts an objective review of financial and investment policy issues and reports to the Board.

The Assurance Committee is a formal sub-committee of the Board. This committee is accountable for seeking assurance that systems, processes and outcomes contribute to the Trust's aims and values and objectives, relating to patient safety and quality, safe and clean hospital environment and staff satisfaction and that there is evidence of robust governance and assurance processes in these areas. The Trust executive committees for clinical governance and general matters report into the Assurance Committee.

Internal Audit services are outsourced to RSM Tenon who provide an objective and independent opinion to the Chief Executive, the Board and the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisation's agreed objectives. Each assignment is discussed with the appropriate line manager or director and a report including management responses and proposed action plan is presented to the Audit Committee. Internal Audit routinely follows up action with management to establish the level of compliance and the results are reported to the Audit Committee.

Executive Directors are accountable to the Board, the Audit Committee and the Assurance Committee for ensuring management arrangements are in place to develop relevant strategies, policies, systems and procedures to maintain internal control and to take action to address any gaps identified from the review of these systems. Executive Directors are responsible for setting team objectives to ensure the delivery of corporate objectives and the management of risk. Any need to change priorities or controls is clearly recorded and actioned as appropriate. There is a quarterly report to the Board on progress on objectives, including a review of the risks.

The Quality Report has been prepared in accordance with our normal systems of control with some additional processes as described above. A review of data quality processes resulted in three recommendations, which are concerned with individual accountability for data quality, a focus on getting data right the first time and integration of data arrangements into business planning and management processes.

A near miss incident involving the theft of a laptop which was not encrypted, but contained no person identifiable data, was treated as a serious incident. All actions from a previous incident were reviewed with an emphasis on assurance and this is an approach which will continue for all serious incidents reported to the Board. The near miss incident was reported to the Information Commissioner and Monitor. The action plan is being monitored by the Board.

A risk relating to maternity services was graded red and reviewed by the Board. The risk was mitigated due to improved recruitment and close monitoring of agency staff.

The Trust has identified a gap in the current risk assessments and Carbon Reduction Delivery Plans but actions are in place to ensure compliance with the Adaptation Reporting requirements of the Climate Change Act.

7. Conclusion

Other than the control issues specified above, of which all have been mitigated or robust plans are in place to do so, there are no other significant control issues.

Heather Lawrence

Heather Lawrence OBE
Chief Executive
27 May 2010

Independent Auditors' Report

Independent Auditors' Report to the Council of Governors and Board of Directors of Chelsea and Westminster Hospital NHS Foundation Trust

We have audited the financial statements of Chelsea and Westminster Hospital NHS Foundation Trust for the year ended 31 March 2010 under the National Health Service Act 2006 ("the Act") which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 36. These financial statements have been prepared in accordance with the accounting policies set out therein.

This report is made solely to the Council of Governors and Board of Directors ("the Boards") of Chelsea and Westminster Hospital NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditors' report and for no other purpose. To the fullest extent permitted by law, we do not, in giving our opinion, accept or assume responsibility to anyone other than the Trust and the Boards, as a body, for this report, or for the opinions we have formed.

Respective responsibilities of the Accounting Officer and Auditors

The Accounting Officer's responsibilities for preparing the financial statements in accordance with directions issued by Monitor, the Independent Regulator of NHS Foundation Trusts, are set out in the Statement of Accounting Officer's Responsibilities.

Our responsibility is to audit the financial statements in accordance with relevant legal and regulatory requirements (including statute and the Audit Code of NHS Foundation

Trusts) and International Standards on Auditing (UK and Ireland).

We report to you our opinion as to whether the financial statements give a true and fair view in accordance with the accounting policies directed by Monitor, the Independent regulator of NHS Foundation Trusts. We also report to you whether in our opinion the information given in the Directors' Report is consistent with the financial statements.

In addition, we report to you if, in our opinion, the financial statements have not been prepared in accordance with directions made under paragraph 25 of Schedule 7 of the Act, the financial statements do not comply with the requirements of all other provisions contained in, or having effect under, any enactment applicable to the financial statements, or proper practices have not been observed in the compilation of the financial statements.

We review whether the statement on internal control reflects compliance with the requirements of Monitor contained in the NHS Foundation Trust Annual Reporting Manual. We report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information we are aware of from our audit of the financial statements. We are not required to consider, nor have we considered, whether the statement on internal control covers all risks and controls. We are also not required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

We read the other information contained in the Annual Report as described in the contents section and consider whether it is consistent with the audited financial statements. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the financial statements. Our responsibilities do not extend to any further information outside the Annual Report.

Basis of audit opinion

We conducted our audit in accordance with the Audit Code for NHS Foundation Trusts issued by Monitor, which requires compliance with International Standards on Auditing (UK & Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements. It also includes an assessment of the significant estimates and judgements made by the Directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error. In forming our opinion we also evaluated the overall adequacy of the presentation of information in the financial statements.

Opinion

In our opinion:

- the financial statements give a true and fair view of the state of affairs of Chelsea and Westminster Hospital NHS Foundation Trust as at 31 March 2010 and of its income and expenditure for the year then ended in accordance with the accounting policies directed by Monitor, the Independent regulator of NHS Foundation Trusts
- the information given in the Directors' Report is consistent with the financial statements

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts.

Heather Bygrave
28 May 2010

Heather Bygrave FCA BA (Hons)
(Senior Statutory Auditor)
For and on behalf of Deloitte LLP
Chartered Accountants
3 Victoria Square, Victoria Street
St Albans AL1 3TF
28 May 2010

Foreword to the accounts

These accounts for the year ended 31 March 2010 have been prepared by Chelsea and Westminster Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

Heather Lawrence

Heather Lawrence OBE
Chief Executive
27 May 2010

Statement of comprehensive income for the year ended 31 March 2010

	Note	IFRS 2009/10 £000	IFRS Restatement 2008/09 £000
Operating income			
Operating income from operations	2	**308,519**	280,636
Operating expenses of operations	3	**(292,483)**	(260,668)
Operating surplus		**16,036**	19,968
Finance costs			
Finance income	7.1	**95**	1,438
Finance expense—financial liabilities	7.2	**(613)**	(856)
Public dividend capital dividends payable		**(8,557)**	(8,687)
Net finance costs		**(9,075)**	(8,105)
Surplus from operations	15.1	**6,961**	11,863
Surplus for the year		**6,961**	11,863
Other comprehensive income			
Revaluation (loss)/gain Property, Plant and Equipment		**(38,246)**	280
Increase in the donated asset reserve due to receipt of donated assets		**155**	240
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets		**(240)**	(212)
Total comprehensive (expense)/income for the year		**(31,370)**	12,171

Statement of financial position as at 31 March 2010

	Note	IFRS 31 Mar 2010 £000	IFRS Restatement 31 Mar 2009 £000	IFRS Restatement 1 Apr 2008 £000
Non-current assets				
Property plant and equipment	8	**265,939**	296,807	283,607
Total non-current assets		**265,939**	296,807	283,607
Current assets:				
Inventories	10	**6,045**	6,588	6,002
Trade and other receivables	11.1	**18,617**	11,418	9,990
Cash and cash equivalents	17	**19,861**	32,053	35,894
Total current assets		**44,523**	50,059	51,886
Current liabilities				
Trade and other payables	13.1	**(27,843)**	(29,347)	(23,146)
Borrowings	14.1	**(919)**	(1,621)	(4,746)
Provisions	16	**(1,896)**	(1,803)	(4,529)
Other liabilities	13.2	**(4,863)**	(2,560)	(4,593)
Total current liabilities		**(35,521)**	(35,331)	(37,014)
Total assets less current liabilities		**274,941**	311,535	298,479
Non-current liabilities				
Borrowings	14.2	**(6,624)**	(12,187)	(13,832)
Provisions	16	**(459)**	(470)	(1,040)
Other liabilities	13.2.1	**(3,450)**	(3,100)	0
Total non-current liabilities		**(10,533)**	(15,757)	(14,872)
Total assets employed		**264,408**	295,778	283,607
Financed by (taxpayers' equity)				
Public dividend capital		**162,549**	162,549	162,549
Revaluation reserve	19	**55,696**	91,320	91,040
Donated asset reserve		**4,986**	7,693	7,665
Income and expenditure reserve		**41,177**	34,216	22,353
Total taxpayers' equity		**264,408**	295,778	283,607

Heather Lawrence

Heather Lawrence OBE, Chief Executive
27 May 2010

Statement of changes in taxpayers' equity for the year ended 31 March 2010

Changes in taxpayers' equity 2009/10	Note	Total £000	Public Dividend Capital £000	Revaluation Reserve £000	Donated Assets Reserve £000	Income & Expenditure Reserve £000
Taxpayers' equity at 1 Apr 2009 as previously stated		**295,778**	162,549	91,320	7,693	34,216
Surplus for the year		**6,961**	0	0	0	6,961
Revaluation (losses) Property, Plant and Equipment		**(38,246)**	0	(35,624)	(2,622)	0
Increase in the donated asset reserve due to receipt of donated assets		**155**	0	0	155	0
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets		**(240)**	0	0	(240)	0
Taxpayers' equity at 31 Mar 2010		**264,408**	162,549	55,696	4,986	41,177
Changes in taxpayers' equity 2008/09						
Taxpayers' equity at 1 Apr 2008 as restated		**279,473**	162,549	91,040	7,533	18,351
Prior period adjustment	**36**	**4,134**	0	0	132	4,002
Taxpayers' equity at 1 Apr 2008—restated		**283,607**	162,549	91,040	7,665	22,353
Surplus for the year		**11,863**	0	0	0	11,863
Revaluation gains Property, Plant and Equipment		**280**	0	280	0	0
Increase in the donated asset reserve due to receipt of donated assets		**240**	0	0	240	0
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets		**(212)**	0	0	(212)	0
Taxpayers' equity at 31 Mar 2009		**295,778**	162,549	91,320	7,693	34,216

Cash flow statement for the year ended 31 March 2010

	IFRS 2009/10 £000	IFRS Restatement 2008/09 £000
Cash flows from operating activities		
Operating surplus from continuing operations	**16,036**	19,968
Non-cash income and expense		
Depreciation	**7,459**	6,121
Transfer from the donated asset reserve	**(240)**	(212)
Increase in trade and other receivables	**(7,199)**	(604)
Decrease/(increase) in inventories	**543**	(586)
Increase in trade and other payables	**1,529**	6,559
Other movements in operating cash flows	**238**	119
Increase/(decrease) in provisions	**82**	(3,344)
Net cash generated from operations	**18,448**	28,021
Cash flows from investing activities		
Interest received	**103**	1,493
Sale of Property, Plant and Equipment	**104**	0
Purchase of Property, Plant and Equipment	**(15,519)**	(19,231)
Net cash used in investing activities	**(15,312)**	(17,738)
Cash flows from financing activities		
Loans repaid	**(6,113)**	(4,594)
Capital element of finance lease rental payments	**(177)**	(180)
Interest paid	**(482)**	(717)
Interest element of finance leases	**(108)**	(143)
PDC dividends paid	**(8,448)**	(8,687)
Cash flows from other financing activities	**0**	197
Net cash used in financing activities	**(15,328)**	(14,124)
Decrease in cash and cash equivalents	**(12,192)**	(3,841)
Cash and cash equivalents at 1 Apr 2009	**32,053**	35,894
Cash and cash equivalents at 31 Mar 2010	**19,861**	32,053

Notes to the accounts

1. Accounting policies and other information

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the accounts and accompanying notes will be prepared in accordance with the 2009/10 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 New and revised standards and interpretations

The following standards, amendments and interpretations have been issued by the International Accounting Standards Board (IASB) and International Financial Reporting Interpretations Committee (IFRIC) but are not yet required to be adopted or are not yet effective.

- IAS 24 related party disclosures (revised 2009)
- IFRS 9 Financial Instruments

The Directors anticipate that the adoption of these standards and interpretations in future period will have no material impact on the financial statements. All other revised and new standards have not been listed here as they are not considered to have an impact on the Trust. Monitor does not permit the early adoption of accounting standards, amendments and interpretations that are in issue at the reporting date but effective at a subsequent reporting period.

1.2 Accounting convention

These accounts have been prepared under the historical cost convention, modified by the revaluation of properties, and, where material, current asset investments and inventories to fair value as determined by the relevant accounting standard.

1.3 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

In accordance with IAS 18, income relating to those spells which are partially completed at the financial year end is apportioned across the financial years on a pro rata basis.

1.4 Expenditure on employee benefits

1.4.1 Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

1.5 Pension costs

NHS Pension Scheme—Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. It is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

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

1.6 Expenditure on other goods and services

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

1.7 Property, Plant and Equipment

1.7.1 Recognition

Property, Plant and Equipment is capitalised where:

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

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

1.8 Measurement

1.8.1 Valuation

All Property, Plant and Equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Properties in the course of construction are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value.

All assets are measured subsequently at fair value as follows:

(a) Land and non-specialised buildings—market value
(b) Specialised buildings—depreciated replacement cost
(c) Non-property assets—depreciated historic cost

The carrying values of Property, Plant and Equipment are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be fully recoverable.

All land and buildings are restated to fair value in accordance with IAS 16 and Monitor guidance, using professional valuations every five years and an interim valuation after three years to ensure that fair values are not materially different from the carrying amounts. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual based on modern equivalent assets.

A valuation of land, buildings and dwellings was carried out by Montagu Evans (Independent Chartered Surveyors, Registration number OC312072). Buildings were valued at depreciated replacement cost on a modern equivalent asset basis as at 31 March 2010. In order to derive relevant build costs, Montagu Evans gave regard to the RICS Build Cost Indices in consultation with their own building surveyor. In accordance with the RICS and Treasury's Financial Reporting manual valuation guidelines, an 'instant build' approach was assumed in that the modern equivalent assets would be constructed at the date of valuation without phasing or lead in periods. It also assumes the site is cleared and ready to take the new buildings and therefore there is no allowance for the demolition of any existing buildings or site preparation.

In arriving at the valuation of the land, Montagu Evans have considered the value for development sites reflecting the expectation that throughout the London Borough where the properties are located, land would be acquired in competition for predominantly residential led, mixed use development. Therefore land was valued having regard to prevailing land values in the vicinity of the existing site.

1.8.2 Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised.

1.8.3 Depreciation

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

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Property, Plant and Equipment are depreciated over the following useful lives:

- Property excluding land: Buildings, installations and fittings are depreciated on a straight line basis, after accounting for residual value, over the remaining useful economic life of 38 years
- Equipment is depreciated on a straight line basis over the useful economic life of the asset, deemed as 5 years for short life assets, 10 years for medium life assets and 15 years for long life assets

1.8.4 Revaluation and impairment

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income.

Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

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

1.9 De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
- the sale must be highly probable ie:
  - (a) management are committed to a plan to sell the asset
  - (b) an active programme has begun to find a buyer and complete the sale
  - (c) the asset is being actively marketed at a reasonable price
  - (d) the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'
  - (e) the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, Plant and Equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.10 Donated assets

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to income and expenditure account. Similarly, any impairment on donated assets charged to the income and expenditure account is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value of the donated asset is transferred from the donated asset reserve to the Income and Expenditure Reserve.

1.11 Private Finance Initiative (PFI) transactions

The Trust is not party to any PFI transactions.

1.12 Intangible assets

1.12.1 Recognition

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

1.12.2 Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

(a) the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
(b) the Trust intends to complete the asset and sell or use it
(c) the Trust has the ability to sell or use the asset
(d) how the intangible asset will generate probable future economic or service delivery benefits eg the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset
(e) adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset
(f) the Trust can measure reliably the expenses attributable to the asset during development

Expenditure which does not meet the criteria for capitalisation is treated as an operating expense in the year in which it is incurred. Where possible, the Trust discloses the total amount of research and development expenditure charged in the Statement of Comprehensive Income separately. However, where research and development activity cannot be separated from patient care activity it cannot be identified and is therefore not separately disclosed.

1.13 Software

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of Property, Plant and Equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

1.14 Measurement

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

Subsequently intangible assets are measured at fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as item of Other Comprehensive Income.

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

1.15 Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.16 Government grants

Government grants are grants from Government bodies other than income from primary care trusts or NHS trusts for the provision of services. Grants from the Department of Health are accounted for as Government grants. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure the grant is held as deferred income and released to operating income over the life of the asset in a manner consistent with the depreciation charge for that asset.

1.17 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In, First Out (FIFO) method.

1.18 Cash and cash equivalents

Cash and cash equivalents comprise of cash on hand and demand deposits and other short term highly liquid investments that are readily convertible to a known amount of cash and are subject to an insignificant risk of changes in value. These balances exclude monies held in the Trust's bank account belonging to patients (see "third party assets" below).

Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases overdrafts are disclosed within payables. Interest earned on bank accounts and interest charged on overdrafts is recorded respectively as "finance income" and "finance cost" in the periods to which they relate. Bank charges are recorded as operating expense in the periods to which they relate.

1.19 Financial instruments and financial liabilities

Financial instruments are defined as contracts that give rise to a financial asset of one entity and a financial liability or equity instrument of another entity. The Trust will commonly have the following financial assets and liabilities: trade receivables (but not prepayments), cash and cash equivalents, trade payables (but not deferred income), finance lease obligations, borrowings, provisions.

1.20 Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs ie when receipt or delivery of the goods or services is made.

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

Regular way purchases or sales are recognised and de-recognised, as applicable, using the trade date.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

1.21 De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risk and rewards of ownership.

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

1.22 Classification and measurement

Financial assets are classified into the following specified categories:

- Financial assets at 'Fair Value through Income and Expenditure'
- 'Loans and receivables'
- 'Available-for-sale' financial assets

Financial liabilities are classified as either:

- Financial liabilities at 'Fair Value through Income and Expenditure'
- 'Other financial liabilities'

The Trust has no financial assets classified as at 'Fair Value through Income and Expenditure' or 'Available for Sale'. There are also no financial liabilities classified as at 'Fair Value through Income and Expenditure'.

1.23 Financial assets and financial liabilities at 'Fair Value through Income and Expenditure'

Financial assets and financial liabilities at 'Fair Value through Income and Expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the Statement of Comprehensive Income. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

The Trust has no financial assets classified as at 'Fair Value through Income and Expenditure', 'Available for Sale'. There are also no financial liabilities classified as at 'Fair Value through Income and Expenditure'.

1.24 Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and 'other receivables'.

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income, except for short-term receivables when the recognition of interest would be immaterial.

1.25 Other financial liabilities

All 'other' financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the balance sheet date, which are classified as non-current liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance Property, Plant and Equipment or intangible assets is not capitalised as part of the cost of those assets.

1.26 Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'Fair Value through Income and Expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred

after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of an allowance account/bad debt provision.

1.27 Leases

1.27.1 Finance leases

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

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

1.27.2 Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

1.27.3 Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

1.28 Provisions

The NHS foundation trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms.

1.29 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at notes to the accounts.

1.30 Non-clinical risk pooling

The NHS foundation trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.31 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets but are disclosed in the notes to the accounts where an inflow of economic benefits is probable. Contingent liabilities are not recognised but are disclosed in the notes to the accounts, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

(a) possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control

(b) present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability

1.32 Public dividend capital

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

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) net cash balances held with the Government Banking Services and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.33 Value Added Tax

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

1.34 Corporation tax

Corporation tax is not applicable to foundation trusts until 2010/11.

1.35 Foreign exchange

The functional and presentational currencies of the Trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'Fair Value through Income and Expenditure') are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined

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

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

1.36 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

2. Operating income from operations

2.1 Operating income (by classification)

Income from activities	Note	IFRS 2009/10 £000	IFRS restatement 2008/09 £000
Elective income		**18,790**	38,112
Non elective income		**64,066**	61,524
Outpatient income		**64,601**	60,679
Accident & Emergency income		**10,380**	9,979
Other NHS clinical income		**97,632**	63,129
Private patient income	2.3	**8,184**	7,969
Other non-protected clinical income		**1,604**	1,963
Total income from activities	2.4	**265,257**	243,355

2.2 Other operating income

	IFRS 2009/10 £000	IFRS restatement 2008/09 £000
Research and development	**4,329**	2,691
Education and training	**24,514**	22,257
Charitable and other contributions to expenditure	**92**	121
Transfers from donated asset reserve in respect of depreciation	**240**	212
Non-patient care services to other bodies	**649**	710
Profit on disposal of equipment	**4**	0
Other income	**13,434**	11,290
Total other operating income	**43,262**	37,281
Total operating income from operations	**308,519**	280,636

2.3 Private patient income

	Base year 2002/03 £000	IFRS 2009/10 £000	IFRS restatement 2008/09 £000
Private patient income	5,498	**8,184**	7,969
Total patient related income	157,015	**265,257**	243,355
Proportion (as percentage)	3.50%	**3.09%**	3.27%

2.4 Operating income (by type)

Income from activities	IFRS 2009/10 £000	IFRS restatement 2008/09 £000
NHS Foundation Trusts	**4**	0
NHS Trusts	**0**	22
Primary Care Trusts	**255,289**	189,447
Department of Health: Other	**176**	43,673
Non NHS: Private patients	**8,184**	7,969
Non NHS: Overseas patients (non-reciprocal)	**1,086**	1,026
NHS injury scheme	**414**	838
Profit on disposal of equipment	**4**	0
Non NHS: Other	**100**	380
Total	**265,257**	243,355

3. Operating expenses from operations

Operating expenses	IFRS 2009/10 £000	IFRS restatement 2008/09 £000
Services from NHS Trusts	**213**	187
Purchase of healthcare from non-NHS bodies	**708**	376
Executive directors costs	**743**	736
Non executive directors costs	**118**	116
Staff costs	**159,796**	147,663
Drug costs	**47,681**	42,240
Supplies and services—clinical (excl drug costs)	**34,944**	29,060
Supplies and services—general	**4,907**	2,777
Establishment	**4,872**	4,600
Research and development	**1,314**	0
Transport	**1,465**	1,446
Premises	**18,627**	16,945
Increase in bad debt provision	**216**	195
Depreciation on Property, Plant and Equipment	**7,459**	6,121
Audit fees:		
Audit services—statutory audit	**109**	105
Audit services—regulatory reporting	**0**	40
Other auditors remuneration—further assurance services	**12**	0
Other auditors remuneration—other services	**10**	0
Clinical negligence	**4,789**	2,873
Loss on disposal of other Property, Plant and Equipment	**168**	118
Other	**4,332**	5,070
Total operating expenses from operations	**292,483**	260,668

3.1 Operating leases

3.1.1 Arrangements containing an operating lease

	IFRS 2009/10 £000	IFRS restatement 2008/09 £000
Minimum lease payments	**1,988**	1,423
Less sublease payments received	**(28)**	(24)
Total	**1,960**	1,399

3.1.2 Arrangements containing an operating lease

Land & Building/Plant & Machinery	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000
Future minimum lease payments due:		
• not later than 1 year	**1,579**	1,052
• later than 1 year and not later than 5 years	**6,729**	3,176
• later than 5 years	**3,040**	2,646
Total	**11,348**	6,874
Total of future minimum sublease lease payments to be received at the balance sheet date	**0**	220

4. Employee expenses and numbers

4.1 Employee expenses

	IFRS 2009/10 £000	IFRS restatement 2008/09 £000
Salaries and wages	**125,233**	114,416
Social security costs	**10,669**	10,040
Employers' contributions to NHS Pension Scheme	**12,481**	12,113
Agency/contract staff	**13,078**	11,403
Total	**161,461**	147,972

4.2 Average number of persons employed (WTE Basis)

	2009/10 N°	2008/09 N°
Medical and dental	**538**	515
Administration and estates	**581**	535
Healthcare assistants and other support staff	**230**	207
Nursing, midwifery and health visiting staff	**1,012**	985
Nursing, midwifery and health visiting learners	**1**	4
Scientific, therapeutic and technical staff	**294**	278
Bank and agency staff	**523**	470
Other	**26**	27
Total	**3,205**	3,021

4.3 Employee benefits

	IFRS 2009/10 £000	IFRS restatement 2008/09 £000
Employee benefits	**69**	427

4.4 Retirements due to ill-health

During 2009/10 there were three (2008/09—nil) early retirements from the Trust agreed on the grounds of ill-health (The estimated additional pension liabilities of ill-health retirements year ended 31 March 2010—£0.2m).

4.5 Salary and pension entitlements of senior managers (table on following page)

Non executive directors do not receive pensionable remuneration therefore there are no entries in respect of pensions for them. A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figure shown relates to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures include the value of any pension benefits in another scheme or arrangement in which the individual has transferred to the NHS pension scheme. They also include any additional pension benefits accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

Real increase in CETV for current year may be significantly different from prior year. This is due to a change in the factors used to calculate CETVs, which came into force on 1 October 2008 as a result of the Occupational Pension Scheme (Transfer Value Amendment) regulation. These placed responsibility for the calculation method for CETVs (following actuarial advice) on Scheme Managers or Trustees. Further regulations from the Department for Work and Pensions to determine cash equivalent transfer values (CETV) from Public Sector Pension Schemes came into force on 13 October 2008.

5. Better Payment Practice Code

5.1 Better Payment Practice Code—measure of compliance

	IFRS 2009/10		IFRS restatement 2008/09	
	N°	£000	N°	£000
Total bills paid in the year	**73,168**	**162,743**	70,804	143,549
Total bills paid within the target	**57,803**	**130,195**	62,628	128,136
Percentage of bills paid within target	**79.0%**	**80.0%**	88.5%	89.3%

The Better Payment Practice Code requires the Trust to aim to pay 95% of all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

5.2 The Late Payment of Commercial Debts (Interest) Act 1998

There were no amounts included within interest expense (note 7.2) arising from claims made under this legislation (2008/09—nil).

6. (Loss) on disposal of fixed assets

The loss on disposal of fixed assets was £0.16m (2008/09—£0.12m) consisting of various pieces of medical equipment decommissioned.

7.1 Finance income

	IFRS 2009/10 £000	IFRS restatement 2008/09 £000
Interest on loans and receivables	**95**	1,438

7.2 Finance costs—interest expense

	2009/10 £000	2008/09 £000
Loans from Foundation Trust Financing Facility	**482**	587
Finance leases	**131**	147
Other loans	**0**	122
Total	**613**	856

4.5 Table of salary and pension entitlements of senior managers

	a) Remuneration		b) Pension				
	Salary for the year ended 31 Mar 2010 bands of **£5,000**	**Salary for the year ended 31 Mar 2009** bands of **£5,000**	**Accrued pension and related lump sum at age 60 as at 31 Mar 2010** bands of **£2,500**	**Real increase/ (decrease) in pension and related lump sum at age 60 as at 31 Mar 2010** bands of **£2,500**	**CETV at 31 Mar 2009** **(£000)**	**CETV at 31 Mar 2010** **(£000)**	**Real increase/ (decrease) in CETV for the year ended 31 Mar 2010** **(£000)**
Executive Directors							
Heather Lawrence, Chief Executive	**170–175**	170–175	**305.0–307.5**	**(5.0)–(2.5)**	1,826	**0**	**0**
Mike Anderson, Medical Director	**150–155**	155–160	**270.0–272.5**	**(20.0)–(17.5)**	1,651	**1,675**	**24**
Lorraine Bewes, Director of Finance & Information	**125–130**	125–130	**120.0–122.5**	**5.0–7.5**	487	**564**	**77**
Amanda Pritchard, Director of Service Integration & Modernisation (Deputy Chief Executive)	**100–105**	85–90	**65.0–67.5**	**2.5–5.0**	158	**183**	**25**
Andrew MacCallum, Director of Nursing	**95–100**	95–100	**130.0–132.5**	**(2.5)–0.0**	547	**601**	**54**
Mark Gammage, Interim Deputy Chief Executive [1]	**35–40**	0	**0**	**0**	0	**0**	**0**
Non-Executive Directors							
Professor Sir Christopher Edwards, Chairman	**35–40**	40–45	**0**	**0**	0	**0**	**0**
Andrew Havery, Non-Executive Director	**15–20**	15–20	**0**	**0**	0	**0**	**0**
Charles Wilson, Non-Executive Director	**15–20**	10–15	**0**	**0**	0	**0**	**0**
Karin Norman, Non-Executive Director	**10–15**	10–15	**0**	**0**	0	**0**	**0**
Professor Richard Kitney, Non-Executive Director	**10–15**	10–15	**0**	**0**	0	**0**	**0**
Colin Glass, Non-Executive Director	**10–15**	10–15	**0**	**0**	0	**0**	**0**
Directors							
Mark Gammage, Interim Director of Human Resources	**120–125**	85–90	**0**	**0**	0	**0**	**0**
Catherine Mooney, Director of Governance & Corporate Affairs	**80–85**	80–85	**110.0–112.5**	**(2.5)–0.0**	496	**538**	**42**
Amit Khutti, Director of Strategy & Service Planning	**80–85**	80–85	**15.0–17.5**	**5.0–7.5**	23	**42**	**19**
Alex Geddes, Director of Information Management & Technology [2]	**55–60**	90–95	**32.5–35.0**	**0.0–2.5**	0	**0**	**0**
William Gordon, Acting Director of Information & Technology [3]	**45–50**	0	**0**	**0**	0	**0**	**0**
Kelda Alleyne, Deputy Director of Finance [4]	**60–65**	0	**0.0–2.5**	**0.0–2.5**	0	**11**	**11**
William Street, Deputy Director of Finance [5]	**55–60**	0	**0.0–2.5**	**0.0–2.5**	0	**10**	**10**
Neil Callow, Deputy Director of Finance [6]	**10–15**	70–75	**80.0–82.5**	**(2.5)–0.0**	293	**323**	**30**

Notes to senior managers' salary and pension table

[1] Started Interim Deputy Chief Executive position from January 2010. Salary for Interim Directors reported as full cost to the Trust.

[2] Left the Trust in November 2009

[3] Started acting position from September 2009

[4] Started employment with the Trust in June 2009

[5] Started July 2009 and left the Trust in February 2010

[6] Left the Trust in May 2009

8. Property, Plant and Equipment

8.1 Property, Plant and Equipment at the balance sheet date 31 March 2010

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 1 Apr 2009									
Owned at 1 Apr 2009	50,000	206,314	0	5,256	18,881	0	6,956	66	287,473
Finance lease at 1 Apr 2009	0	0	1,014	0	627	0	0	0	1,641
Donated at 1 Apr 2009	0	6,958	0	0	735	0	0	0	7,693
NBV Total at 1 Apr 2009	**50,000**	**213,272**	**1,014**	**5,256**	**20,243**	**0**	**6,956**	**66**	**296,807**
Cost or valuation at 1 Apr 2009	50,000	222,936	1,269	5,256	40,330	65	14,516	537	334,909
Additions—purchased	0	5,809	108	4,074	1,963	1	2,868	128	14,951
Additions—donated	0	0	0	0	35	120	0	0	155
Impairments charged to revaluation reserve	0	(51,804)	0	0	0	0	0	0	(51,804)
Reclassifications	0	3,255	60	(4,936)	(414)	0	2,003	32	0
Other revaluations	0	0	564	0	0	0	0	0	564
Disposals	0	0	0	0	(1,168)	0	0	0	(1,168)
Cost or valuation at 31 Mar 2010	**50,000**	**180,196**	**2,001**	**4,394**	**40,746**	**186**	**19,387**	**697**	**297,607**
Accumulated depreciation at 1 Apr 2009 as restated	0	9,664	255	0	20,087	65	7,560	471	38,102
Provided during the year	0	3,040	34	0	2,780	0	1,594	11	7,459
Revaluation impairment/surplus	0	(12,704)	(289)	0	0	0	0	0	(12,993)
Disposal	0	0	0	0	(900)	0	0	0	(900)
Depreciation at 31 Mar 2010	**0**	**0**	**0**	**0**	**21,967**	**65**	**9,154**	**482**	**31,668**
Net book value									
Owned at 31 Mar 2010	50,000	176,005	0	4,394	17,614	1	10,233	215	258,462
Finance lease at 31 Mar 2010	0	0	2,001	0	490	0	0	0	2,491
Donated at 31 Mar 2010	0	4,191	0	0	675	120	0	0	4,986
NBV Total at 31 Mar 2010	**50,000**	**180,196**	**2,001**	**4,394**	**18,779**	**121**	**10,233**	**215**	**265,939**
Net book value at 31 Mar 2010									
Protected assets at 31 Mar 2010	50,000	180,196	2,001	0	0	0	0	0	232,197
Unprotected assets at 31 Mar 2010	0	0	0	4,394	18,779	121	10,233	215	33,742
Total at 31 Mar 2010	**50,000**	**180,196**	**2,001**	**4,394**	**18,779**	**121**	**10,233**	**215**	**265,939**

8.2 Property, Plant and Equipment at the balance sheet date 31 March 2009

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 1 Apr 2008									
Owned at 1 Apr 2008	50,000	200,832	1,107	2,237	16,964	2	4,781	19	275,942
Finance lease at 1 Apr 2008	0	0	0	0	0	0	0	0	0
Donated at 1 Apr 2008	0	7,102	0	0	563	0	0	0	7,665
NBV Total at 1 Apr 2008	**50,000**	**207,934**	**1,107**	**2,237**	**17,527**	**2**	**4,781**	**19**	**283,607**
Cost or valuation at 1 Apr 2008	50,000	214,914	1,269	2,237	36,565	65	11,462	471	316,983
Additions—purchased	0	3,430	0	8,050	4,599	0	2,774	66	18,919
Additions—donated	0	0	0	0	240	0	0	0	240
Reclassifications	0	4,592	0	(5,031)	439	0	0	0	0
Other revaluations	0	0	0	0	0	0	280	0	280
Disposals	0	0	0	0	(1,513)	0	0	0	(1,513)
Cost or valuation at 31 Mar 2009	**50,000**	**222,936**	**1,269**	**5,256**	**40,330**	**65**	**14,516**	**537**	**334,909**
Accumulated depreciation at 1 Apr 2008 as previously stated	0	11,088	188	0	19,038	63	6,681	452	37,510
Depreciation—prior period adjustment	0	(4,108)	(26)	0	0	0	0	0	(4,134)
Accumulated depreciation at 1 Apr 2008 as previously stated	0	6,980	162	0	19,038	63	6,681	452	33,376
Provided during the year	0	2,684	93	0	2,444	2	879	19	6,121
Disposal	0	0	0	0	(1,395)	0	0	0	(1,395)
Depreciation at 31 Mar 2009	**0**	**9,664**	**255**	**0**	**20,087**	**65**	**7,560**	**471**	**38,102**
Net book value									
Owned at 31 Mar 2009	50,000	206,314	1,014	5,256	19,512	0	6,956	66	289,118
Finance lease at 31 Mar 2009	0	0	0	0	0	0	0	0	0
Donated at 31 Mar 2009	0	6,958	0	0	731	0	0	0	7,689
NBV Total at 31 Mar 2009	**50,000**	**213,272**	**1,014**	**5,256**	**20,243**	**0**	**6,956**	**66**	**296,807**
Net book value at 31 Mar 2009									
Protected assets at 31 Mar 2009	50,000	209,915	1,014	0	0	0	0	0	260,929
Unprotected assets at 31 Mar 2009	0	3,357	0	5,256	20,243	0	6,956	66	35,878
Total at 31 Mar 2009	**50,000**	**213,272**	**1,014**	**5,256**	**20,243**	**0**	**6,956**	**66**	**296,807**

9. Net book value of assets held under finance leases contracts at the balance sheet date

9.1 Finance lease assets

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Dwellings	**2,001**	1,014	1,107
Plant and machinery	**490**	627	771

9.2 Total amount of depreciation charged to the income and expenditure account in respect of assets held under finance lease

	IFRS 2009/10 £000	IFRS restatement 2008/09 £000
Dwellings	**34**	93
Plant and machinery	**137**	144

10/10.1 Inventories

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Inventories			
Raw materials & consumables	**6,045**	6,588	6,002
Inventories recognised in expenses			
Write-down of inventories	**1,100**	0	0

11. Trade receivables and other receivables

11.1 Current receivables

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
NHS receivables	**13,483**	6,565	6,026
Provision for impaired receivables	**(2,736)**	(2,574)	(2,502)
Prepayments	**837**	458	684
Accrued income	**901**	312	766
Other receivables	**6,132**	6,657	5,016
Total current trade and other receivables	**18,617**	11,418	9,990

12. Provision for impairment of receivables

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
At 1 April	**2,574**	2,502	2,502
Increase in provision	**1,165**	195	0
Amounts utilised	**(54)**	(123)	0
Unused amounts reversed	**(949)**	0	0
At 31 March	**2,736**	2,574	2,502

12.1 Analysis of impaired receivables

Ageing of impaired receivables	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Up to three months	**133**	195	0
In three to six months	**678**	121	148
Over six months	**1,925**	2,258	2,354
Total	**2,736**	2,574	2,502

12.2 Ageing of non-impaired receivables past due date

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Up to three months	**9,184**	3,206	3,019
In three to six months	**913**	979	431
Over six months	**4,117**	1,488	0
Total	**14,214**	5,673	3,450

13. Trade and other payables

13.1 Current liabilities

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
NHS payables	**7,151**	7,798	6,116
Trade payables—capital	**395**	1,076	1,235
Accruals	**9,032**	10,036	6,187
Other payables	**5,277**	10,437	9,608
Other trade payables	**5,879**	0	0
PDC payable	**109**	0	0
Total current liabilities	**27,843**	29,347	23,146

13.2 Other liabilities

Current liabilities	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Deferred income	**4,863**	2,560	4,593
Total other current liabilties	**4,863**	2,560	4,593

13.2.1 Non-Current Liabilities

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Deferred government grant	**3,450**	3,100	0
Total other non-current liabilties	**3,450**	3,100	0

14. Borrowings

14.1 Current borrowings

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Loans from Foundation Trust Financing Facility	**756**	1,470	1,470
Obligations under finance leases	**163**	151	152
Other loans	**0**	0	3,124
Total current borrowings	**919**	1,621	4,746

14.2 Non-current borrowings

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Loans from Foundation Trust Financing Facility	**4,161**	9,560	11,030
Obligations under finance leases	**2,463**	2,627	2,802
Total non-current borrowings	**6,624**	12,187	13,832

15. Finance lease obligations

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Gross lease liabilities	**3,563**	3,827	4,124
of which liabilities are due:			
• not later than one year	**267**	264	260
• later than one year and not later than five years	**971**	1,093	1,114
• later than five years	**2,325**	2,470	2,750
	3,563	3,827	4,124
Less: finance charges allocated to future periods	**(937)**	(1,049)	(1,169)
Net lease liabilities	**2,626**	2,778	2,955
of which liabilities are due:			
• not later than one year	**163**	152	141
• later than one year and not later than five years	**646**	731	704
• later than five years	**1,817**	1,895	2,110

15.1 Finance lease commitments

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Minimum payments	**3,563**	3,827	4,124
Number of years of commitment	**18**	19	20

16. Provisions for liabilities and charges

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Pensions relating to other staff	**453**	440	408
Other provisions including short time employment benefit	**1,902**	1,833	5,161
Total provisions for liabilities and charges	**2,355**	2,273	5,569

	Pensions— other staff £000	Others including employee benefit £000	Total £000
At 1 Apr 2009	440	1,833	**2,273**
Arising during the year	29	69	**98**
Utilised during the year	(16)	0	**(16)**
Reversed unused	0	0	**0**
At 31 Mar 2010	**453**	**1,902**	**2,355**
Expected timing of cash flows:			
• not later than one year	41	1,855	**1,896**
• later than one year and not later than five years	48	0	**48**
• later than five years	364	47	**411**
Total	**453**	**1,902**	**2,355**

Clinical Negligence Liabilities

Amount included in provisions of the National Health Service Litigation Authority at 31 March 2010 in respect of clinical negligence of the Trust is £40.48m (2008/09—£31.32m).

17. Cash and cash equivalents

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Balance at 1 Apr 2009	**32,053**	35,894	35,894
Net change in year	**(12,192)**	(3,841)	0
Balance at 31 Mar 2010	**19,861**	32,053	35,894
17.1 Comprising:			
Commercial banks and cash in hand	**742**	67	16,815
Cash with Office of HM Paymaster General	**19,119**	31,986	19,079
Cash and cash equivalents as in statement of cash flows	**19,861**	32,053	35,894

18. Prudential Borrowing Limit (PBL)

	31 Mar 2010		31 Mar 2009	
	Authorised £000	Actual £000	Authorised £000	Actual £000
Total long term borrowing	**56,700**	**7,543**	38,100	13,222
Working capital facility	**20,000**	**20,000**	20,000	20,000
Total	**76,700**	**27,543**	58,100	33,222

		IFRS 31 Mar 2010		IFRS restatement 31 Mar 2009	
Financial ratios	**Prudential borrowing limits**	**Approved PBL ratio**	**Actual PBL ratio**	**Approved PBL ratio**	**Actual PBL ratio**
Minimum dividend cover (times)	>1.0x	**3.9x**	**2.7x**	2.9x	3.1x
Minimum interest cover (times)	>3.0x	**49.7x**	**38.5x**	29.6x	34.4x
Minimum debt service to revenue (%)	>2.0x	**5.7x**	**3.7x**	4.8x	5.1x
Maximum debt service to revenue (%)	<3.0%	**2.1%**	**2.0%**	2.1%	1.9%

The Trust is required to comply and remain within a prudential borrowing limit. This is made up of two elements:

- the maximum cumulative amount of long term borrowing. This is set by reference to the five ratio tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit.
- the amount of any working capital facility approved by Monitor.

Further information on the NHS Foundation Trust Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

19. Revaluation Reserve

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Revaluation reserve at 1 Apr 2009—restated	**91,320**	91,040	91,040
Revaluation (losses)/gains and impairment losses on Property, Plant and Equipment	**(35,624)**	280	0
Revaluation reserve at 31 Mar 2010	**55,696**	91,320	91,040

20. Third party assets

The Trust held £0.05m cash at bank and in hand at 31 March 2010 (2008/09—£0.05m) which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

21. Contractual capital commitments

Commitments under capital expenditure contracts at 31 March 2010 were £0.5m (2008/09—£0.97m).

22. Post balance sheet events

There have been no post balance sheet events since the balance sheet date.

23. Contingencies

There were no contingent liabilities at the balance sheet date.

24. Related party transactions

Chelsea and Westminster Hospital NHS Foundation Trust is a public benefit corporation established by the order of the Secretary of State for Health.

Government Departments and their agencies are considered by HM Treasury as being related parties.

25. Main commissioners

	IFRS 31 Mar 2010	
Main commissioners	**Income £000**	**Expenditure £000**
NHS Kensington and Chelsea	99,503	319
NHS Hammersmith and Fulham	37,637	64
NHS Westminster	23,883	29
NHS Wandsworth	27,255	396
Other government departments and central bodies:		
• HM Revenue & Customs	0	39,796
• NHS Business Services Authority	0	5,487
• NHS Litigation Authority	0	4,803

25.1 Main Commissioners	**Accounts Receivables £000**	**Accounts Payables £000**
NHS Kensington and Chelsea	3,301	30
NHS Hammersmith and Fulham	656	52
NHS Westminster	571	51
NHS Wandsworth	703	446
Other government departments and central bodies:		
• HM Revenue & Customs	0	3,449
• NHS Business Services Authority	0	425

The Trust has also received income from Chelsea and Westminster Health Charity as donations towards revenue and capital expenditure. No funds are held in trust by Chelsea and Westminster Hospital NHS Foundation Trust but are held by the Trustees, who prepare the Charity's accounts independently of the Trust.

26. PFI schemes

The Trust is not party to any PFI schemes.

27. Losses and special payments

There were 68 cases of losses and special payments (2008/09—81 cases) totalling £0.06m (2008/09—£0.28m) for the year ended 31 March 2010.

28. Financial Instruments

IAS 32 (Financial Instruments: Disclosure and Presentation), IAS 39 (Financial Instrument Recognition and Measurement) and IFRS 7 (Financial Instruments: Disclosures) require disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The Trust does not have any complex financial instruments and does not hold or issue financial instruments for speculative trading purposes. Because of the continuing service provider relationship the Trust has with primary care trusts and the way those primary care trusts are financed, the Trust is not exposed to the degree of financial risk faced by non NHS business entities.

The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Finance and Investment Committee manages the Trust's funding requirements and financial risks in line with the Board approved treasury policies and procedures and their delegated authorities.

The Trust's financial instruments comprise loans, finance lease obligations, provisions, cash at bank and in hand and various items, such as trade debtors and trade creditors, that arise directly from its operations. The main purpose of these financial instruments is to raise finance for the Trust's operations.

29. Categories of Financial Instruments

29.1 Financial assets

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Loans and receivables (including cash)	**37,642**	43,013	45,199
Total	**37,642**	43,013	45,199

29.2 Financial liabilities

	IFRS 31 Mar 10 £000	IFRS restatement 31 Mar 09 £000	IFRS restatement 1 Apr 08 £000
Other financial liabilities (amortised cost)	**34,262**	39,827	40,796
Total	**34,262**	39,827	40,796

30. Book values of financial assets & liabilites

	Book value		
	31 Mar 10 £000	**31 Mar 09 £000**	**1 Apr 08 £000**
Financial assets	**19,861**	32,053	35,894
Financial liabilities			
Finance leases obligation for more than 1 year	**2,463**	2,627	2,802
Loans due in more than 1 year	**4,161**	9,560	11,030
Total	**6,624**	12,187	13,832

30.1 Fair values of financial assets & liabilites

	Fair value		
	31 Mar 10 £000	31 Mar 09 £000	1 Apr 08 £000
Financial assets	**19,861**	32,053	35,894
Financial liabilities			
Finance leases obligation for more than 1 year	**2,463**	2,627	2,802
Loans due in more than 1 year	**4,161**	9,560	11,030
Total	**6,624**	12,187	13,832

As allowed by IFRS 7, short term trade debtors and creditors measured at amortised cost may be excluded from the above disclosure as their book values reasonably approximate their fair values.

31. Liquidity and interest risk tables

31.1 Financial assets

	Weighted avg interest rate (%)	Less than 1 year £000	1–2 years £000	2–5 years £000	More than 5 years £000	Total £000
Non-interest bearing		17,780	0	0	0	17,780
Fixed interest rate instrument	0.45%	19,861	0	0	0	19,861
Variable interest rate instrument		0	0	0	0	0
Gross financial assets at 31 Mar 2010		**37,641**	**0**	**0**	**0**	**37,641**
Non-interest bearing		10,960	0	0	0	10,960
Fixed interest rate instrument	5.03%	32,053	0	0	0	32,053
Variable interest rate instrument		0	0	0	0	0
Gross financial assets at 1 Apr 2009		**43,013**	**0**	**0**	**0**	**43,013**

31.2 Financial liabilities

	Weighted avg interest rate (%)	Less than 1 year £000	1–2 years £000	2–5 years £000	More than 5 years £000	Total £000
Non-interest bearing		24,441	0	0	0	24,441
Finance lease liability	3.50%	267	271	699	2,327	3,564
Fixed interest rate instrument	4.85%	756	756	756	2,649	4,917
Provisions under contract		1,867	42	42	327	2,278
Gross financial liabilities at 31 Mar 2010		**27,331**	**1,069**	**1,497**	**5,303**	**35,200**
Non-interest bearing		26,165	0	0	0	26,165
Finance lease liability	3.50%	125	129	408	2,470	3,132
Fixed interest rate instrument	4.92%	1,482	1,482	4,446	4,060	11,470
Gross financial liabilities at 1 Apr 2009		**27,772**	**1,611**	**4,854**	**6,530**	**40,767**

32. Interest rate risk

100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. Chelsea and Westminster Hospital NHS Foundation Trust was not, therefore, exposed to significant interest rate risk.

33. Liquidity risk

The Trust's net operating costs are mainly incurred under legally binding contracts with primary care trusts, which are financed from resources voted annually by Parliament. This provides a reliable source of funding stream which significantly reduces the Trust's exposure to liquidity risk.

The Trust also manages liquidity risk by maintaining banking facilities and loan facilities to meet its short and long term capital requirements through continuous monitoring of forecast and actual cash flows.

In addition to internally generated resources the Trust finances its capital programme through a loan facility, while the working capital is backed by a committed facility of £20m, unused at 31 March 2010. Details are included in note 18.

34. Credit risk

Credit risk exists where the Trust can suffer financial loss through default of contractual obligations by a customer or counterparty.

Trade debtors consist of high value transactions with primary care trusts under contractual terms that require settlement of obligation within a time frame established generally by the Department of Health.

Other trade debtors include private and overseas patients, spread across diverse geographical areas. Credit evaluation is performed on the financial condition of accounts receivable and, where appropriate, sufficient prepayment is required to mitigate the risk of financial loss.

Credit risk exposures of monetary financial assets are managed through the Trust's treasury policy which limits the value that can be placed with each approved counterparty to minimise the risk of loss. The counterparties are limited to the approved financial institutions with high credit ratings. Limits are reviewed regularly by senior management.

The Trust's net operating costs are mainly incurred under legally binding contracts with Primary Care Trusts, which are financed from resources voted annually by Parliament.

This provides a reliable source of funding stream which significantly reduces the Trust's exposure to liquidity risk.

The Trust also manages liquidity risk by maintaining banking facilities and loan facilities to meet its short and long term capital requirements through continuous monitoring of forecast and actual cash flows.

35. Operating segments

The Board of Directors is of the opinion that the Trust's operating activities fall under the single heading of healthcare for the purpose of operating segments disclosure.

IFRS 8 requirements were considered and the Trust has determined that the Chief Operating Decision Maker is the Trust Board of Chelsea and Westminster Hospital NHS Foundation Trust.

It is the responsibility of the Trust Board to formulate financial strategy and approve budgets. Significant operating segments that are reported internally are the ones that are required to be disclosed in the financial statements.

There is no segmental reporting for revenue, assets or liabilities to the Trust Board. Expenditure is reported by segment to the Trust Board. However those segments fully satisfy the aggregation criteria to be one reportable segment as per IFRS 8.

Therefore all activities of the Trust are considered to be one segment, 'Healthcare', and there are no individual reportable segments on which to make disclosures.

36. Transition to IFRS

	Retained earnings £000	Revaluation reserve £000	Donated asset reserve £000	Government grant reserve £000	Total £000
Taxpayers' equity at 31 Mar 2009 under UK GAAP	**29,289**	**91,320**	**7,472**	**0**	**128,081**
Adjustments for IFRS changes:					
Leases	42				**42**
Employee benefits	(1,785)				**(1,785)**
Adjustments for:					
UK GAAP errors*	6,670		221		**6,891**
Taxpayers' equity at 1 Apr 2009 under IFRS	**34,216**	**91,320**	**7,693**	**0**	**133,229**

Surplus/(deficit) for 2008/09 under UK GAAP	9,634
Adjustments for:	
Leases	(12)
Employee benefits	(427)
Adjustments for:	
UK GAAP errors*	2,668
Surplus/(deficit) for 2008/09 under IFRS	**11,863**

* Depreciation of £6.891m relating to residual value of the buildings has been adjusted as a UK GAAP error in the Accounts. The adjustment has been reflected in the IFRS 2008/09 restatement and 1 April 2008 opening balance for the prior year element. £4.134m relates to prior year which has been adjusted in the 1 April 2008 opening balance as follows: increase to Income and Expenditure Reserve £4.002m; increase to Donated Assets Reserve £0.132m and increase to Property, Plant and Equipment £4.134m. The depreciation relating to 2008/09 was adjusted as follows: £2.668m in the restated 2008/09 Operating Surplus and £0.089m in Donated Assets Reserve.

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Council of Governors Meeting, 16 September 2010

AGENDA ITEM NO.	2.2/Sep/10
PAPER	External Auditors' Report to the Council of Governors
AUTHOR	Heather Bygrave – Partner – Audit, Deloitte LLP
LEAD	Heather Bygrave – Partner – Audit, Deloitte LLP
EXECUTIVE SUMMARY	This paper summarises the key issues arising from the work on the audit carried out by the Deloitte LLP for the year ended 31st March 2010.
DECISION/ ACTION	The Council of Governors is asked to note the report.

Deloitte.

Chelsea & Westminster Hospital NHS Foundation Trust

Report to Council of Governors Meeting on the year ended 31 March 2010

16 September 2010

31 August 2010

Contents

Executive summary

We have pleasure in setting out in this document details of our work for Chelsea & Westminster Hospital NHS Foundation Trust ("the Trust") for the year ended 31 March 2010. This summary is not intended to be exhaustive but highlights the most significant matters to which we would like to bring to your attention.

	Description
Audit of the financial statements	We were able to issue an unqualified opinion on the Trust's 2009/10 accounts ahead of the 8 June 2010 deadline set by the Department of Health. Our opinion confirmed that the accounts gave a true and fair view of the Trust's financial affairs and of the income and expenditure recorded by the Trust. We reported the findings of our audit to the Trust's Audit Committee on 24 May 2010. Further detail is given in Section 1. Our audit requires us to focus on a number of key risks and we reported in detail the results of our audit work on these areas to the Audit Committee on 24 May 2010. We would like to bring to your attention the results of our work on the property valuation risk as we believe this is particularly relevant given the Trust's proposed expansion plans. In the 2009/10 accounts a £38.2m impairment in relation to the value of the buildings owned by the Trust impacted on the total revenue recorded by the Trust in the year. Investigation has highlighted that the driving factor in the size of the impairment this year is the cumulative additions which have been made to buildings over the last four years which have not been considered by the valuer to generate a corresponding increase in the value of the buildings. The Trust is embarking on a significant capital redevelopment programme over the next three years and this matter could have a significant impact on the revenue account as additions to buildings which do not increase the value of the asset will need to be impaired. We would recommend that the Trust engages with its valuer in order to understand the potential impact and to perform some scenario planning in order to limit the effect on medium term financial planning.
Dry-run review of external assurance on Quality Report	In April 2010, Monitor issued guidance for a dry-run of the external assurance proposals on the 2009/10 Quality Reports. This confirmed that auditors would not be providing an opinion on the 2009/10 Quality Reports, but would report on the key findings and recommendations with a view to giving a published audit opinion in 2010/11. Our work on the 2009/10 Quality Report indicated that, in order for us to be able to give an unqualified opinion in 2010/11, the Trust will need to improve the audit trail and accuracy of the information that feeds into the indicators included in the Quality Report. However, from our work at other London NHS Foundation Trusts and attendance at Auditor Group meetings we understand that a conclusion of this sorts on the 2009/10 Quality Report is not uncommon. We reported our findings to the Director of Finance and Director of Governance & Corporate Affairs on 12 July 2010. Further detail is given in Section 2 and in our accompanying report 'Dry-run Review of External Assurance on the 2009/10 Quality Report'.
Benchmarking analysis	We have reviewed the 2010/11 Annual plan submitted by the Trust to Monitor. Monitor has awarded the Trust: • Financial risk rating – 4 out of 5 (with 5 being the lowest risk) • Governance risk rating– Green • Mandatory goods and services – Green Further detail is given in Section 3.

Executive summary (continued)

Review of the White Paper: *Equity and excellence: liberating the NHS*	The Government published its White Paper: *Equity and excellence: liberating the NHS* ("White Paper") in July 2010. The White Paper sets out a large number of reforms to enable the achievement of the Government's aims and indicates an extension to the role that Monitor will have within the Health Sector. Practically, this will mean a change to the existing commissioning arrangements and the Trust will need to develop arrangements with its GP consortia to ensure future contracts with these organisations are sufficient to meet the Trust's plans. Further detail is given in Section 4.
Transactions in the Health Sector	2009/10 has seen some of the first competitive merger and acquisition ("M&A") transactions in the Health Sector. Deloitte is engaged by Strategic Health Authorities, Primary Care Trusts, NHS Foundation Trusts (acute and mental health), NHS trusts and aspirant social enterprises to provide due diligence and advisory services in connection with the Transforming Community Services agenda. This gives us a wide and deep 360 degree insight into how transactions are being executed and what progress is being made. Through our close links with Monitor we also have insight into their process and view of these transactions. Please see Section 5 for more information on these transactions. .
Professional fees	Audit fees in relation to the year ended 31 March 2010 were £90k (2009: £97.5k). In addition to this we billed £20k in 2009/10 for our work on the Quality Report (2009: £nil). An analysis of total fees is shown in Appendix 1.

1. Audit of the financial statements

We have set out below the key findings from our audit:

Results of the audit	We were able to issue an unqualified opinion on the Trust's accounts on 28 May 2010, 11 days in advance of the 8 June 2010 deadline set by the Department of Health. Before we give our opinion on the accounts, we are required to report to the Trust's Audit Committee significant matters arising from the audit. A detailed report was presented to the Trust's Audit Committee on 24 May 2010. Our opinion confirms that the accounts give a true and fair view of the Trust's financial affairs and of the income and expenditure recorded by the Trust during the year. We are also required to report on the Trust's value for money arrangements. Based on our interviews and review of documentation, we found that the Trust has the minimum standards in place with respect to securing value for money in the year ended 31 March 2010. We therefore made no reference in our audit report to any qualification matters in respect of the Trust's overall value for money arrangements in 2009/10.
Audit efficiencies	The Trust informed us earlier in the year that it wished to sign the accounts in advance of the Department of Health deadline and signing on the 28 May 2010 is a considerable achievement by the Trust, particularly given that this was the first year the Trust was required to report under International Financial Reporting Standards ("IFRS"). To assist the Trust with this goal, we worked with the Trust's finance team in advance of the audit and we introduced a secure web based information sharing facility which proved to be extremely effective. We also maintained continuity within the audit team to promote efficiencies and facilitate a faster audit process. In addition to this the Trust were extremely organised which enabled us to start audit work earlier than in previous years, and throughout the audit the Trust were receptive and responded to audit queries in a fast and efficient manner.
Property valuations	Our audit requires us to focus on a number of key risks and we reported in detail the results of our audit work on these areas to the Audit Committee on 24 May 2010. We would like to bring to your attention the results of our work on the property valuation risk as we believe this is particularly relevant given the Trust's proposed expansion plans. **Results of audit work** In the 2009/10 accounts property, plant and equipment ("PPE") was held at a value of £265.9m which represented a decrease of £30.9m in that year. Although the Trust had a number of additions in the year, the main reason for the decrease in value was a £38.2m impairment in relation to the value of the buildings owned by the Trust. This impacted on the total revenue recorded by the Trust in the year. This impairment was reported by Montagu Evans, who the Trust engaged to provide the valuation at 31 March 2010. The size of the impairment is notable, particularly in the context of a confirmation received from Montagu Evans in the prior year that the building values were still materially correctly valued, despite the previous valuation being done as at 1 April 2006. Investigation has highlighted that the driving factor in the size of the impairment this year is the cumulative additions which have been made to buildings over the last four years which have not been considered by the valuer to generate a corresponding increase in the value of the buildings. The valuation method under IFRS means that it is the cost of replacing the asset in question, not the cost involved in actually creating it in the first place, which is reflected in the accounts.

1. Audit of the financial statements (continued)

Property valuations (continued)	**Looking forward** As the Trust embarks on a significant capital redevelopment programme over the next three years, which we understand to be in the order of £100m, this matter could have a significant impact as additions to buildings which do not increase the value of the asset will need to be impaired. This could potentially have an impact on the revenue account in the year of impairment. We understand that Monitor currently do not take impairment charges going through the revenue accounts into consideration when compiling their financial risk ratings, but this should be confirmed with the Trust's relationship manager or by reference to the compliance framework. We would recommend that the Trust engages with its valuer in order to understand the potential impact and to perform some scenario planning in order to limit the effect on medium term financial planning. The current downward movements in the building cost indicators are unusual compared to historic trends. Forecasting how long the decline will last, or how quickly indices will recover, will be very difficult to do, but the changes are likely have a significant bearing on the financial plans of the Trust.

2. Dry-run review of external assurance on the 2009/10 Quality Report

Background	In April 2010, Monitor issued guidance for a dry-run of the external assurance proposals on the 2009/10 Quality Reports. This confirmed that auditors would not be providing an opinion on the 2009/10 Quality Reports, but would report on the key findings and recommendations with a view to giving a published audit opinion in 2010/11. The guidance also confirmed that the Trust was responsible for providing a copy of their auditors' report on the outcome of the dry-run to Monitor by 30 July 2010, and to the Trust's Council of Governors.

Work performed on the 2009/10 Quality Report	During June and July 2010, based on guidance provided by Monitor, we undertook work at the Trust on the 2009/10 Quality Report in anticipation of providing a report to the Trust on 22 July 2010. Our work involved: • a review on the arrangements the Trust Board has put in place to prepare and publish the Quality Report against Monitor's published set of criteria which mandate investigation in the following five areas: governance and leadership; policies; systems and processes; people and skills; and data use and reporting; • detailed sample testing of the systems to support the preparation of three mandated performance indicators prescribed by Monitor: MRSA; Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers ("62 days"); and 18 weeks data ("18 weeks"); • production of a report to the Trust Board of our findings and recommendations for improvements, in anticipation of a published audit opinion in the 2010/11 Quality Report.

Results of our work	We reported our findings to the Director of Finance and Director of Governance & Corporate Affairs on 12 July 2010. As required by Monitor, we have prepared a separate detailed report on the findings from the dry run review of external assurance on the 2009/10 Quality Report and this has been included in a separate report to the Council of Governors on 16 September 2010. Although there are recommendations that we have made in relation to the arrangements the Trust has in place for preparing and publishing the Quality Report, overall the Trust has performed well in this area. However, our detailed testing of the three mandated indicators has indicated significant gaps or errors in information to support the sample being tested. In order for us to be able to give an unqualified opinion in 2010/11, the Trust will need to improve the audit trail and accuracy of the information that feeds into the indicators included in the Quality Report. From our work at other London NHS Foundation Trusts and attendance at Auditor Group meetings we understand that a conclusion of this sort on the 2009/10 Quality Report is not uncommon.

3. Benchmarking analysis

Introduction	As the Trust operates within the Foundation Trust arena, it continues to be increasingly important for the Trust to perform well financially. It is also important for management and the Board to be reviewing and approving budgets and cash flow forecasts that are based on robust assumptions and realistic expectations. NHS foundation trusts are required each year to submit their three-year plans to Monitor whose relationship managers review the plans in detail to consider the expected challenges, potential investment opportunities and service development over the next three years. Each NHS foundation trust is assigned governance and financial risk ratings, based on the self-certifications and returns in their plan.

Summary of Monitor's analysis of the Annual plans	Monitor has recently reviewed the annual plans of the 129 NHS Foundation Trusts authorised at 31 March 2010. Key points identified by Monitor from this review are: • 39 (30%) NHS Foundation Trusts have forecast a decline in their financial risk rating in 2010-11; • income growth of 1.7% is forecast in 2010-11. However, over the three years of the plan, income is expected to decline by 0.8%; • average cost improvement plans (CIPs) of 4.4% in 2010-11 are higher than Foundation Trusts have achieved before (3% in 2009/10); • 95 NHS Foundation Trusts (74%) forecast a 'green' rating for governance in 2010/11; 25 (19%) declared themselves as 'amber-green' for 2010-11; six were amber-red; and three Trusts forecast a 'red' rating; and • 53 (41%) Foundation Trusts have highlighted potential acquisitions in their plans. These are primarily driven by Primary Care Trusts disposing of their provider functions.

Chelsea & Westminster Annual plan	We have reviewed the 2010/11 Annual plan submitted by the Trust to Monitor. Key points identified by the Trust are: • The Trust is forecasting income growth of 1.9% in 2010/11. However, by 2012/13 this is forecast to decline in comparison to the 2009/10 income by 2.5%. • The Trust is forecasting a CIP of 7.4% of costs in 2010/11. Monitor has awarded the Trust: • Financial risk rating – 4 out of 5 (with 5 being the lowest risk) • Governance risk rating– Green • Mandatory goods and services – Green Please see Appendix 2 for a summary of how all NHS Foundation Trusts have performed in these areas.

4. Review of White Paper: *Equity and excellence: liberating the NHS*

Review of White Paper	The Government published its White Paper: *Equity and excellence: liberating the NHS* ("White Paper") in July 2010. The aim of the White Paper was to: • Put patients at the heart of everything the NHS does; • Focus on continuously improving the thing that really matters to patients – the outcome of their healthcare; and • Empower and liberate clinicians to innovate, with the freedom to focus on improving healthcare services. The White Paper sets out a wide number of reforms to enable the achievement of these aims. They key reforms of interest to the Trust are likely to be: • The Government will devolve power and responsibility for commissioning services to the healthcare professionals closest to the patients: GPs and their practice teams working in consortia. The Government expects a comprehensive system of GP consortia to be in place in shadow form during 2011/12 with transitional arrangements in place to ensure that existing expertise and capability in Primary Care Trusts (PCTs) is maintained during this period. The intention is that GP consortia will take on full financial responsibility from April 2013, at which point PCTs will cease to exist. • To support GP consortia in their commissioning decisions the statutory NHS Commissioning Board will be created to provide leadership for quality improvement through commissioning. From 2010 Strategic Health Authorities ("SHAs") will separate their commissioning and provider oversight functions and will be required to support the NHS Commissioning Board during its preparatory year; SHAs will then be abolished from 2012/13.
Impact on the Trust	Practically, this will mean a change to the existing commissioning arrangements and the Trust will need to develop arrangements with its GP consortia to ensure future contracts with these organisations are sufficient to meet the Trust's plans.

Changing role of Monitor	Within three years the Government aims to support all NHS Trusts to become NHS Foundation Trusts. From April 2013, Monitor will take on the responsibility of regulating all providers of NHS care, irrespective of their status. Monitor will become the economic regulator responsible for promoting effective and efficient health and care, regulating prices and safeguarding the continuity of services.

Changes to the Audit Commission	On 13 August 2010, the Secretary of State for Communities and Local Government announced the proposed abolition of the Audit Commission. The proposed abolition will be from March 2012 and the Audit Commission has confirmed that there is no immediate change to its audit arrangements. New audit arrangements are likely to apply from the start of the 2012/13 financial year and this may see the National Audit Office having more involvement in this area. The Audit Commission is currently responsible for a number of auditor appointments within the Health Sector. The Trust currently has the power to appoint its own auditors, and we will keep you informed of further developments in this area.

5. Transactions in the Health Sector

2009/10 has seen some of the first competitive merger and acquisition ("M&A") transactions in the Health Sector. Deloitte assisted with a number of ground breaking transactions. We have included a summary of these below and the potential impact on the Trust.

Mergers and acquisitions activity within the Sector	
Background	Deloitte assisted with a ground breaking transaction involving Bedfordshire and Luton Partnership Trust ("BLPT"), which was identified as a Trust unlikely to ever achieve NHS Foundation Trust status in its own right. In a competitive tender process run by NHS East of England, South Essex Partnership University NHS Foundation Trust emerged as the successful bidder and preferred acquirer of BLPT. Deloitte also assisted The Christie NHS Foundation Trust, the largest single site cancer centre in Europe, to move forward with its plans to form a joint venture with an independent sector operator to develop its private patient cancer services. We are seeing more activity in the area of NHS Foundation Trusts 'acquiring' the community services businesses of Primary Care Trust provider arms and we are undertaking due diligence work in this area for a number of NHS Foundation Trusts. We are also providing due diligence work on material transactions for Royal United Hospital Bath NHS Trust and Salford NHS Foundation Trust. Further opportunities exist around forming alliances rather than undertaking formal M&A activity, in order to take advantage of economies of scale in a number of back office functions.
Impact on the Trust	As activity of this type becomes more prevalent in the NHS, and with a number of 'challenged' Trusts being in the London area, further M&A activity is highly likely to take place. The Trust will want to consider the potential options which may be available to it in progressing against its medium to long term strategy, as well as any additional options which may arise when considering efficiency savings. Given the expanding role of Monitor described in the White Paper it seems likely that in the future Monitor will be more involved reviewing transactions and that there may be a high level of challenge and scrutiny.

6. Closing remarks

Our Final Audit Committee report was discussed with the Director of Finance and was presented to the Audit Committee on 24 May 2010. Our report on the Dry-run review of external assurance on the 2009/10 Quality Report was discussed with the Director of Finance and Director of Governance & Corporate Affairs on 12 July 2010.

We would like to take this opportunity to express our appreciation for the assistance and co-operation provided during the course of all of our work during the year. Our aim is to deliver a high standard of service which makes a positive and practical contribution which supports the Trust's own agenda. We recognise the value of your co-operation and support.

We view this report as part of our service to you for use as Governors of Chelsea & Westminster Hospital NHS Foundation Trust for Corporate Governance purposes and it is to you alone that we owe a responsibility for its contents.

This report should be read in conjunction with the "Briefing on audit matters" circulated to you in December 2007 and sets out those audit matters of governance interest which came to our attention during the audit. Our audit was not designed to identify all matters that may be relevant to the Council of Governors and this report is not necessarily a comprehensive statement of all deficiencies which may exist in internal control or of all improvements which may be made.

We would be happy to consider a request to perform a more extensive study of these matters and, where compatible with our independence as auditors, assist you with implementing any improvements. As you will appreciate, such an exercise would be a separate engagement to our audit appointment, since the scope and context of our audit work in these areas is necessarily limited.

This report has been prepared for the Council of Governors, as a body, and we therefore accept responsibility to you alone for its contents. We accept no duty, responsibility or liability to any other parties, since this report has not been prepared, and is not intended, for any other purpose. It should not be made available to any other parties without our prior written consent.

For your convenience, this document has been made available to you in electronic format. Multiple copies and versions of this document may therefore exist in different media - in the case of any discrepancy the final signed hard copy should be regarded as definitive. Earlier versions are drafts for discussion and review purposes only.

Deloitte LLP
Chartered Accountants

August 2010

Appendix 1: Analysis of professional fees

The professional fees earned by Deloitte in respect to the period 1 April 2009 to 31 March 2010 are as follows:

	Year ended 31 March 2010 £'000	Year ended 31 March 2009 £'000
Fees payable to the Trust's auditors for the audit of the company's annual accounts	85	92.5
Fees payable to the Trust's auditors for the Value for Money conclusion	5	5
Audit fees – statutory audit	**90**	**97.5**

At the date of the Audit Committee meeting no future services have been contracted for or written proposals submitted. In addition to the above audit fees, the Trust has commissioned Deloitte to conduct:

	Year ended 31 March 2010 £'000	Year ended 31 March 2009 £'000
A review of the Trust's arrangements for preparing the 1 April 2008 opening IFRS balance sheet.	-	9
Audit of the 31 March 2009 IFRS balance sheet	12	-
Fees payable to the Trust for the dry-run review of external assurance on the 2009/10 Quality Report	20	-
Other auditors remuneration – further assurance services	**32**	**9**
Smart benefit review	10	5
Review of IT security and data governance (1)	12	-
Other auditors remuneration – other services	**22**	**5**

(1) This work began in the year ending 31 March 2009 and was completed and billed in the year ended 31 March 2010.

Appendix 2: Benchmarking analysis

The tables below show the risk ratings of all 129 NHS Foundation Trusts that were authorised as at 31 March 2010. This is the latest available information obtained from the Monitor website. The assigned criteria for the three categories indicate:

- Financial risk rating (rated 1-5, where 1 represents the highest risk and 5 the lowest);
- Governance (rated red, amber or green); and
- Mandatory goods and services (rated red, amber or green).

Financial risk rating	Number of NHS Foundation Trusts
1	2
2	5
3	41
4	75
5	6
Total	**129**

The Trust is included in the level 4 category within the Financial risk rating.

	Number of NHS Foundation Trusts	
Rating	Governance risk rating	Mandatory services risk rating
Red	21	0
Amber	28	0
Green	80	129
Total	**129**	**129**

The Trust is included in the 'green' category for the Governance risk and Mandatory services risk ratings.

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Member of Deloitte Touche Tohmatsu

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 16 September 2010

AGENDA ITEM NO.	2.3/Sep/10
PAPER	Audit Committee Annual Report 2009/10
AUTHOR	Lorraine Bewes, Director of Finance and Information
LEAD	Andrew Havery, Chairman Audit Committee
EXECUTIVE SUMMARY	The NHS Foundation Trust Code of Governance (section F.3.2) provides that the Audit Committee should report to the Council of Governors, identifying any matters in respect of which it considers that action or improvement is needed and to make recommendations as to the steps to be taken. This report outlines key Audit Committee activity for the financial year 2009/10. This was also reported to the Board of Directors in June 2010. It provides evidence for the assurances that have been made to the Board with regard to the Trust's risk management, internal control and governance processes being adequate and effective. The report summarises the external assurance received during the year from internal audit, external audit and the local counter fraud specialist and also identifies issues that have been noted for improvement in these areas. The opinion of the Committee was that the Trust's risk management, control and governance processes are adequate and effective and may be relied upon by the Board. The opinion of the Committee is that the Trust's risk management, control and governance processes are adequate and effective and may be relied upon by the Board.
DECISION/ ACTION	The Council of Governors is asked to note the report of the Audit Committee.

CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST

Report of the Audit Committee for financial year 2009/10

1.0 Introduction

1.1 The NHS Foundation Trust Code of Governance (section F.3.2) provides that the Audit Committee should report to the Council of Governors, identifying any matters in respect of which it considers that action or improvement is needed and to make recommendations as to the steps to be taken.

1.2 This report outlines key Audit Committee activity for the financial year 2009/10. This was also reported to the Board of Directors in June 2010. It provides evidence for the assurances that have been made to the Board with regard to the Trust's risk management, internal control and governance processes being adequate and effective. The report summarises the external assurance received during the year from internal audit, external audit and the local counter fraud specialist and also identifies issues that have been noted for improvement in these areas.

2.0 Audit Committee's Opinion

2.1 The opinion of the Committee, based on the issues set out in section 3 below, is that the Trust's risk management, control and governance processes are adequate and effective and may be relied upon by the Board. Assurance given can never be absolute. The highest level of assurance that can be provided is reasonable assurance that there are no major weaknesses in the Trust's risk management, control and governance processes.

3.0 Information supporting Opinion

3.1 Summarised below is the key information / sources of assurance that the Committee has relied upon when formulating our opinion.

3.2 Internal Audit

3.2.1 The Head of Internal Audit has provided his opinion of the overall adequacy and effectiveness of the organisation's risk management, control and governance processes for the year ended 31st March 2010.

3.2.2 The opinion is positive and concludes that:

'Based on the work undertaken in 2009/10, significant assurance can be given that there is a sound system of internal control, designed to meet the organisation's objectives, and that controls are being applied consistently.'

This is a positive opinion with no caveats and represents an improvement on 2008/09 when weaknesses in the inconsistent application of controls were identified for the achievement of 18 weeks and CNST Level 2. Both objectives in the event were achieved.

3.2.3 The tables below show Chelsea and Westminster Hospital NHS Foundation Trust's performance for the 2009/10 year, benchmarked against the 2008/09 year. Overall, this performance represents a steady improvement on last year:

a) 100% of audits have substantial or adequate assurance this year, compared with 90% in 2008/09. Of two areas that were rated limited last year (CNST evidence review and 18 weeks), 18 weeks this year has moved to substantial and the Trust responded to the limited assessment and passed Level 2 last year.
b) Assurance on audits covering financial systems has improved last year with 83% substantial compared with 67% substantial last year. Asset Register has improved and Payroll remains adequate.
c) The drop in the % of substantial assurance is due to Trust targeting a wider number of operational areas where there was considered to be a risk to the delivery of the related corporate objective. This year the Trust achieved adequate assurance in Bank and Agency, Contracted-Out Services, Governance Effectiveness of Committees and Patient Experience. Last year there were fewer areas covered but they were substantial (Infection Control, CNST pre assessment review).
d) The Trust has made improvements between 2008/09 and 2009/10 in respect of both the number of significant recommendations made and in respect of the number of limited assurance reports issued. However, it should be noted that a number of advisory reviews have been undertaken during 2009/10 where a formal opinion has not been provided, but where the purpose of the review has been to assist the Trust in development of individual areas or processes, for example in respect of the clinical governance systems.

Average Levels of Assurance

Assurance	Substantial	Adequate	Limited
This client 2009/10	**50%**	**50%**	**0%**
This client 2008/09	**63%**	**27%**	**10%**

Number of Recommendations

Recommendations	Fundamental	Significant	Merits Attention
This client 2009/10	**0**	**1.3**	**3.65**
This client 2008/09	**0**	**1.42**	**2.42**

3.2.2 For the year to 31st March 2010, the Head of Internal Audit considered that there were no issues that needed to be brought to the attention of Trust Management that he considered relevant to the Statement of Internal Control.

3.3 External Audit

3.3.1 The external auditors reported to the Audit Committee on 24th May 2010 on the accounts prepared for the year to 31st March 2010 and a separate report to the Council of Governors has been prepared under Agenda item 2.1. The external auditors issued an unqualified audit opinion. The accounts were approved at the Board on 27th May and delivered to Monitor within the required timescale (8th June). The financial results for the period delivered a financial risk rating of 4, which provides an excellent Use of Resources rating

by the Care Quality Commission (previously Healthcare Commission) for the financial year 2009/10 maintaining the excellent rating awarded since its inception as an FT in 2006/07.

3.3.2 Use of Resources: External audit are required to review the Trust's use of resources and to be satisfied that proper arrangements have been made for securing economy, efficiency and effectiveness in the use of resources. It is anticipated that their review will identify no matters that needed to be reported as an exception.

3.3.3 The Audit Committee reviewed the Quality Accounts on 24th May and considered how assurance over the data quality of the 2009/10 Quality Report was given to the Board when they adopted the accounts for submission on 8th June. This year is a dry run and external audit's report to the Directors is considered under a separate Agenda item 2.5. Next year external audit will provide this assurance as part of their statutory audit.

3.4 Other Committees

3.4.1 The Trust had two other assurance committees during the year. These are the Assurance Committee and the Finance and Investment Committee (FIC).

3.4.2 The Assurance Committee assures the Board that systems, processes and outcomes contribute to the Trust's aims and values and objectives, relating to patient safety and quality, safe and clean hospital environment and staff satisfaction and that there is evidence of robust governance and assurance processes in these areas.

3.4.4 The FIC assures the Trust Board on financial and investment policy issues, including oversight of material capital investment business cases. All these committee minutes are made available to the Audit Committee.

3.5 Local Counter Fraud Service (LCFS)

3.5.1 Each NHS body is required to take necessary steps to counter fraud under instructions from the Secretary of State's Directions. As a Foundation Trust, this is one our contractual requirements with PCTs. The Trust has complied with these Directions by agreeing an Annual Service Level Agreement with Parkhill for the delivery of the Local Counter Fraud Service for 2009/10, which includes a proactive counter fraud programme to detect fraud as well as investigations in response to alleged frauds. The Audit Committee receives a regular report on progress against the agreed work plan and annual report.

3.5.2 The Counter Fraud and Security management Service (CFSMS) carries out an annual assessment of the strengths and weaknesses of Local Counter Fraud and bands NHS bodies into one of four compound indicators. The ratings achievable are designated 1 – 4, 4 being the highest. The Trust scored a level 3 in 2008/09 (2007/08 – level 2), which is performing well. Within the CI document a level 3 is described as:

'To achieve a level 3 performance and assess the health body as performing well, the arrangements at level 2 should be embedded and operating effectively with clear outcomes. In addition to achieve level 3 assurances for work completed must clearly be evident and must clearly demonstrate qualitative outputs.'

3.5.3 The Compound Indicator assessment for work conducted in 2009/10 has been submitted to CFSMS and will be confirmed later this year.

3.5.4 During the year, the Audit Committee has been aware of press allegations around Parkhill's billing arrangements. The Director of Finance has conducted an internal review of our bills and has concluded that the Trust has been appropriately charged for the work carried out. The Audit Committee will keep this under review.

3.5.5 Counter fraud arrangements are compliant with the Secretary of State's Directions.

3.6 Assurance Framework

3.6.1 The Audit Committee approved the Assurance Framework for 2009-10 at the meeting in May 2009. The Audit Committee confirmed that it accurately represented the key risks associated with the achievement of objectives for the trust.

4.0 <u>The Role and Operation of the Audit Committee</u>

4.1 Membership of the Committee

4.1.1 The members of the Committee during the period of the Report were as follows:

Andrew Havery (Chair of the Committee)
Charlie Wilson
Karin Norman

In addition the Chief Executive, Director of Finance, Deputy Chief Executive, External Auditors, Internal Auditors, Local Counterfraud Specialist and Director of Governance and Corporate Affairs are in attendance.

4.1.2 The members of the Committee disclosed their interests, which included the following, in the Trust's register of interests:-

Andrew Havery:
- Councillor, Westminster City Council
- Member of the Board of the CityWest Homes ALMO
- Vice Chair of Governors for Quintin Kynaston Specialist Technology College
- NHS Practice Management, Dr Lee's Surgery
- Finance Director, Mind Sports Olympiad

Karin Norman:
- Trustee, Nursing and Midwifery Council and Associated Employers Pension Scheme
- Chair, MyGeneration (registered charity)
- Director, Raglan Capital Ltd
- Audit Committee and Investment Committee, Parkinson's UK

Charles Wilson

- Trustee of Addaction, currently vice-chairman. (Addaction is a leading drugs treatment charity)
- Non-Exec Director of the-racehorse.co.uk (a commercial online horseracing news site)
- Trustee Royal Naval Museum
- Member of the Board of the Countryside Alliance

4.1.3 The Committee was supported by Paulina Woodberry.

4.2 Operation of the Committee

4.2.1 Meetings and attendance

The Committee is required to meet quarterly in line with the terms of reference. Meetings took place during the period and were attended as follows:

	21st May 2009	2nd June 2009	23rd July 2009	22nd Oct 2009	21st Jan 2010	19th Mar 2010	TOTALS	
							No of meetings	%
Andrew Havery	*P*	*P*	*P*	*P*	*P*	*P*	*6/6*	*100%*
Karin Norman	*A*	*P*	*P*	*P*	*A*	*P*	*4/6*	*67%*
Charlie Wilson	*P*	*P*	*A*	*P*	*P*	*A*	*4/6*	*67%*
TOTAL	*67%*	*100%*	*67%*	*100%*	*67%*	*67%*	*14/18*	*78%*

Key – P (Present for meeting) A (Absent from meeting) N/A (Not applicable)

The quorum for meetings of the Committee was 67%. As the table above shows all meetings of the Committee during the period were quorate.

4.2.2 Committee Self Assessment

The Committee undertook a self assessment as to its performance using the template recommended in the Audit Committee handbook in May 2009. No material deficiencies were found. The Committee will next undertake a self assessment in September 2010.

4.2.3 Performance Indicators

During the year the Committee has established performance indicators for External Audit and has agreed performance indicators for Local Counter Fraud Service. Performance indicators for Internal Audit are already in place and the Internal Audit Service reports on achievement of these indicators within each progress report. Performance indicators for assessing External Audit performance will be reviewed at the Audit Committee scheduled after the accounts are approved, at the September meeting. The Local Counter Fraud Service indicators are reported in the regular progress reports.

We consider there are no issues about their performance that affects their ability to support this Committee in discharging its duties.

5.0 Conclusions

5.1 Based on the information presented and discussed at the Audit Committee meetings during the year we have concluded:

5.2 Risk Management

5.2.1 The Trust's system of risk management including adequacy of the risk identification, recording, reporting and monitoring arrangements is outlined in the Statement on Internal Control (SIC). The SIC was approved at the meeting of 24th May and was approved by internal and external audit.

5.3 Governance Arrangements

5.3.1 Governance Arrangements

Internal Audit undertook a review of committee effectiveness plus noted adequate assurance. The Committee also received a report on the Trust's position taking into account the Audit Commission report taking it on Trust' PCT.

5.3.2 Council of Governors

The results of an advisory review were that the Trust Board was working well with the Council. It was agreed that the Trust could be assured that there were adequate systems in place.

5.4 Standards for Better Health declaration

The Audit Committee noted that there was a robust evidence tool for monitoring compliance. Internal audit confirmed there was adequate evidence for the standards submitted.

5.5 Statement on Internal Control

5.5.1 The Statement on Internal Controls (SIC) has been produced for 2009/10 and incorporates a number of key changes, including an increased focus on data security, and efficient plus effective use of resources. The SIC was approved by internal and external audit at the Audit Committee on 24th May and its content is consistent with the conclusions above.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 16 September 2010

AGENDA ITEM NO.	2.4/Sep/10
PAPER	Appointment of External Auditor
AUTHOR	Kelda Alleyne, Deputy Director of Finance
LEAD	Lorraine Bewes, Director of Finance and Information
EXECUTIVE SUMMARY	Last year the Council of Governors agreed to tender the External Auditors contract from 2010/11. Tendering has commenced, from which we will be awarding the contract to the winning supplier. The tender timeline is such that we propose to award contract from January 2011, in time to commence the fieldwork for the 2010/11 Annual Accounts. The Council of Governors will be requested to formally appoint the auditors at its December meeting. This will be based on the recommendation of the Audit Committee following evaluation of the tender submissions in November 2010. Key dates are as follows: • 24th Aug 2010- Close date for expressions of interest- complete • 9th Sept 2010- Questionnaires returned by Suppliers- complete • 31st Oct 2010- Tender opening completion • 2nd Dec 2010- Council of Governors approves appointment • 1st Jan 2011- Contract starts
DECISION/ ACTION	The Council is asked to note the intention to appoint External Auditors from January 2011 based on the outcome of a formal tender evaluation.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 16 September 2010

AGENDA ITEM NO.	2.5/Sep/10
PAPER	Dry-run Review of External Assurance on the 2009/10 Quality Report
AUTHOR	Heather Bygrave – Partner – Audit, Deloitte LLP
LEAD	Heather Bygrave – Partner – Audit, Deloitte LLP
EXECUTIVE SUMMARY	This paper summarises the results of the dry-run review of external assurance on the 2009/10 Quality Report.
DECISION/ ACTION	The Council of Governors is asked to note the report.

Dry-run Review of External Assurance on the 2009/10 Quality Report

Chelsea & Westminster Hospital NHS Foundation Trust Report

30 July 2010

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1. Executive summary

In April 2010, Monitor issued guidance for a dry run of the external assurance proposals on the 2009/10 Quality Reports. This confirmed that auditors would not be providing an opinion on the 2009/10 Quality Reports, but would report on the key findings and recommendations with a view to giving a published audit opinion in 2010/11. The guidance also confirmed that the Trust is responsible for providing a copy of their auditors' report on the outcome of the dry-run to Monitor by 30 July 2010, and to the Trust's Board of Governors.

The objectives of our state of readiness review were to:

- review and report on the arrangements the Foundation Trust Board has put in place to prepare and publish the Quality Report against Monitor's published set of criteria, in anticipation of providing a published reasonable assurance opinion in 2010/11;
- undertake sample testing of the systems to support the preparation of three performance indicators, as prescribed by Monitor, in anticipation of providing a published limited assurance opinion in 2010/11; and
- provide a report to the Trust Board of their findings and recommendations for improvements, in anticipation of a published audit opinion in the 2010/11 Quality Report.

Conclusion

Although there are recommendations that we have made in relation to the arrangements the Trust has in place for preparing and publishing the Quality Report, overall the Trust has performed well in this area. However, our detailed testing of the 3 mandated indicators has indicated significant errors or gaps in information to support the sample being tested. In order for us to be able to give an unqualified opinion in 2010/11, the Trust will need to improve the audit trail and accuracy of the information that feeds into the indicators included in the Quality Report.

1.1 Key findings on the arrangements review

The key findings from our review, based on a review of key documentation and interviews with individuals across the Trust, are as follows:

- **Governance and Leadership**

  There is clear corporate leadership of data quality by those charged with governance at the Trust. A senior individual has responsibility for information governance and data quality. In 2009/10 the Director of Finance had responsibility for both governance and data quality; in 2010/11 data quality became the responsibility of the Interim Deputy Chief Executive. Data quality objectives are laid out in the Information and Data Quality Policy, which clearly sets out responsibilities across a range of posts at the Trust. There is a process in place by which data quality is monitored, with channels through the governance structure up to those charged with governance. Data quality issues are also embedded in the assurance framework, with specific risks around data quality being identified and monitored.

- **Policies**

  There is comprehensive guidance for staff relating to data quality, starting with the Information and Data Quality Policy, and flowing into tailored training depending on staff role and IT system used. Policies and procedures build in the requirements of national standards, rules, definitions, and guidance, as well as local practices and monitoring arrangements. Policies and procedures are reviewed periodically and updated when necessary. All relevant staff have access to policies, guidance and support on data quality. Policies, procedures and guidance are understood to be applied consistently, although our detailed testing identified some instances where data had been incorrectly recorded and we have therefore assigned an amber rating to 1 category in this area. We have not raised a separate recommendation in relation to this point as it is covered by recommendations in other sections.

- **Systems and Processes**

  While there are some processes in place to check, validate and correct data which has been incorrectly recorded, the policies and processes are designed to be right first time. However, due to the errors identified in the detailed testing of the 3 mandated indicators we have assigned an amber rating to 1 category in this area; please refer to Section 8 for more detail on our findings.

  Arrangements for collecting, recording and reporting data are built into business planning and management processes, supporting the day to day work of staff. While information systems are automated in some respects, there are examples of manual spreadsheets being used to manage data. There are also examples where reporting of national indicators cannot be done through direct interface with the Trust's systems, and manual processes are required. We have assigned an amber rating to 1 category in this area as these manual processes leave the Trust exposed to error; please refer to Section 8 for more detail on our findings.

Recommendations

1) On the 18 week and 62 day indicators there is reliance by the Trust on manual processes, for example reliance on the correct recording of the referral to treatment ("RTT") and clinical outcome forms at the input stage of the process. Another example of manual processes is during the validation stage of the 18 week process due to exceptions caused by the 'freeze date issue'. To minimise the potential for human error or manipulation in the process, effort should be made to ensure that wherever possible, system controls assist with data validation, ensuring the correct recording of data from the point of entry.
2) Where manual spreadsheets are used, there should be a review process to ensure human error does not impact on reported information. The review process should be proportionate and risk based. For example, within the 62 day process a manually populated Excel spreadsheet is provided to the Information Team at the Trust for monthly reporting. Our detailed testing identified errors on the data in this spreadsheet.
3) The process for recording the 18 week and 62 day indicators places much reliance on the information recorded in the RTT and clinical outcome forms. A sample of RTT and other clinical forms should be retained on a periodic basis (daily / weekly) for all individuals inputting data from them in order for line managers to review the data recorded against the original forms. This should also incorporate some degree of challenge where events along a patient pathway do not appear logical to ensure appropriate information is recorded on the RTT or clinical forms in the first place.

- **People and Skills**

Roles and responsibilities in relation to data quality are clearly defined in the Information and Data Quality Policy, and are described in job descriptions where relevant. There is a programme of training which is tailored to needs, periodically evaluated and updated. There is a performance appraisal process where relevant staff are assessed on data quality aspects of their performance. However, the Quality Report for 2009/10 states that only 76% of staff have had an appraisal in the previous 12 months (information collected through a staff survey). Although this is stated as high for an acute Trust, we have assigned an amber rating to 1 area in this category as it may be that staff with key data quality responsibilities fall within the percentage not having had a recent appraisal. Arrangements are in place to ensure temporary staff are inducted and aware of policies relevant to their area of work.

Recommendation

1) Through its HR department, the Trust should validate the staff survey response that 76% of staff have had an appraisal in the last 12 months. We understand that efforts have been made by the Trust in 2009/10 to raise the profile of staff appraisals but recommend that a plan be put in place to ensure that all staff receive an appraisal at least every 12 months.

- **Data Use and Reporting**

  Internal reporting requirements have been reviewed in the light of new targets, and a refreshed performance report has been created for 2010/11. Data reported to those charged with governance is also used for day to day management of the Trust's business. Data is used to support decision making, and there is evidence of corrective action being taken by the Trust to address service delivery issues identified in reporting. Data trends are analysed and triangulated with information from other sources, such as patient feedback and complaints, in order to identify issues. Data used for external reporting is subject to verification procedures however, the detailed testing identified errors and a lack of audit trail in relation to some patients selected and we have therefore assigned an amber rating to 1 category in this area.

  Recommendation

  1) To minimise the possibility of discrepancies existing between the indicator in the Quality Report and the supporting data provided by the Trust, for all reported indicators, there should be a record of how the information recorded by the Trust reconciles to the Quality Report and nationally submitted data. Where information is subject to a reconciliation process, this should be reviewed by management, evidenced as such, and retained in the manner of other audit working papers.

1.2 Key findings on the detailed data testing

We performed sample testing on each of the 3 mandated performance indicators that have been prescribed by Monitor: MRSA bacteraemia ("MRSA"), Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers ("62 days"); and 18 weeks data ("18 weeks").

The procedures we performed did not constitute a review or an audit of any kind. We did not subject the information contained in our Report or given to us by the Directors to checking or verification procedures except to the extent expressly stated in section 8. This is normal practice when carrying out such limited scope procedures, but contrasts significantly with, for example, an audit. The procedures we performed were not designed to and are not likely to reveal fraud. We have not performed any tests over the completeness or summarisation of reports provided to us by management.

The key findings from our detailed testing are as follows, please refer to Section 8 for more information on the detailed testing and the Action Plan in Section 10 for more information on the recommendations:

- **Findings not specific to 1 indicator**

  Our detailed testing identified that the information reported in the Quality Report for the 62 days and 18 week indicators did not reconcile back to the underlying data on the Trust's system. Although the discrepancies do not result in a target being breached the discrepancies noted are as follows:

18 week non-admitted pathway – Quality Report indicates 98.97% compared to the population data provided by the Trust of 98.75%;
18 week admitted pathway – Quality Report indicates 93.40% compared to the population data provided by the Trust of 93.22%; and
62 days pathway – Quality Report indicates 93.01% compared to summary performance data provided by the Trust of 93.12%

These differences do not alter the fact that the Trust has met its targets on these indicators and, if the Trust had reported whole integers in the Quality Report, these differences would not have been identified. For more details on the reasons for these differences please refer to Section 8.

Non-specific recommendations

1) Figures for inclusion in the Quality Report should be taken from data once the validation process is complete and should be reconciled back to supporting documentation. Reconciliations, including a check that patients from all systems (e.g. genitourinary medicine ("GUM")) have been included, should be reviewed by management and signed to indicate that this process has taken place.

2) The differences on the percentage recorded in the Quality Report in comparison to the population data provided would not have been an issue if the Trust had reported the indicator to nil decimal places in line with the presentation of the target indicator. We recommend that the Trust bring reporting on the individual indicators in line with the presentation of the target.

- **MRSA bacteraemia ("MRSA")**

Our testing selected the 10 MRSA cases reported by the Trust for the year ended 31 March 2010. We identified one case where the Trust was unable to extract the necessary patient information from Lastword.

Recommendation

Recommendations around the issues encountered during our testing have been raised in other areas of the report, primarily the Data Use and Reporting section, and are not repeated here.

- **62 days**

  Our testing selected 25 patients whose pathway had been closed during the 6 months ended 31 March 2010 (NB for 2010/11 we will require a population that covers the 12 months to 31 March 2011). We identified errors on information recorded for 7 patient pathways (1 with a negative impact, 3 with a positive impact, and 3 with no impact on 'breach/non breach' status) recorded in the Quality Report. In addition to this there were 5 patient pathways where we were either unable to agree to supporting patient notes or were unable to confirm the impact on the Quality Report. These issues have been documented in Section 8 of this report.

  Recommendations

  1) To allow the Trust to document an audit trail, as recommended in the Cancer Reform Strategy (2007), 'End of treatment' summary sheets should be produced for each patient on the 62 day pathway and signed by a member of the clinical team.

  2) Our review of documentation indicated that the clinical outcome proformas were updated in the year. Our testing of these documents indicated that 2 different layout of forms were being used. Effort should be made to ensure that 1 clinical outcome proforma is used which contains information on the effect on the clock of each code.

  3) To check that patients are being correctly recorded on the monthly report provided to the performance team, on a quarterly basis a sample of results for each specialty should be validated.

  4) To assist staff with tracking of patient information, procedures for defining and categorising types of cancer should be clarified and communicated to all staff involved in the process.

  5) To allow the Trust to document a complete audit trail, effort should be made to ensure that, where treatment takes place at other organisations, documentation confirming clock start and stops dates is obtained and retained on the patient file.

  Please see Section 10 for the Trust's response to these recommendations.

- **18 weeks – non-admitted pathway**

  Our testing selected 18 patients from the cardiology and general surgery specialties whose pathway had been closed in the year ended 31 March 2010. We identified known errors on information recorded for 4 patient pathways of which 3 would have had a negative impact on the percentage recorded in the Quality Report, with the remaining error having no impact (i.e. no change in 'non breach' status). There were 9 patient pathways where we were either unable to agree to supporting patient notes or were unable to confirm the impact on the Quality Report. These issues have been documented in Section 8 of this report.

- **18 weeks –admitted pathway**

  Our testing selected 7 patients from the cardiology and general surgery specialties whose pathway had been closed in the year ended 31 March 2010. We identified that there were 3 patient pathways where we were either unable to agree to supporting patient notes or were unable to confirm the impact on the Quality Report. These issues have been documented in Section 8 of this report.

  Recommendations

  1) To assist in capturing all clock stops, consultants should be encouraged to fill out a referral to treatment ("RTT") form (NB an RTT form captures the result of the clinicians appointment and includes detail on the coding to be input onto Lastword) for patients who do require clock stops even if no follow up appointment is required.

  2) To assist in minimising errors by the clinicians on coding of the RTT forms, effort should be made to emphasise the importance of the RTT form in capturing information for the 18 week pathway.

  3) To reduce the errors on start date caused by the 'freeze date issue' weekly validation information and all reporting on clock stops should be moved to the patient target/waiting lists spreadsheets known as the "pathway PTL" which is purely based on pathway identifications from 1 August 2009 and looks at the last RTT outcome, next planned activity and whether this will cause a breach.

  4) To check that patients clocks have been stopped correctly, validation checks should be extended to patients whose clocks have been stopped to confirm that these patients have been treated correctly on the system rather than just focussing on clocks that are about to breach.

  Please see Section 10 recommendations 6 to 16 for the Trust's response to all of the data testing recommendations.

1.3 Considerations for 2010/11 Quality Report detailed testing

Although the specific requirements of the external assurance over the 2010/11 Quality Report are yet to be finalised, our detailed testing for this dry run process has identified that a degree of assurance needs to be placed on the Trust's electronic patient record systems. Chelsea & Westminster Hospital NHS Foundation Trust is ahead of many Trusts in terms of electronic data storage. Some specialities and areas of the Trust no longer use manual forms to record information, whilst some incorporate more manual processes. Depending on the specific areas of focus for 2010/11, and what specific processes are employed in those areas, we will require a degree of assurance over the Trust's systems supporting the indicators being tested. Where there are fewer manual processes which we are able to test, a greater degree of assurance over the systems is required. Once the requirements for 2010/11 are understood, we will work with the Trust to document its processes in those areas and perform the testing necessary to obtain assurance over the electronic systems during the 2010/11 year.

2. Introduction

Under the Health Act 2009 and the National Health Service (Quality Accounts) Regulation 2010, providers of NHS care are required to prepare and publish Quality Accounts for each financial year from 2009/10. Each organisation is responsible for submitting their 2009/10 Quality Account for publication on the NHS Choices website by 30 June 2010.

Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) along with additional reporting requirements outlined within Monitor's annual reporting guidance. The 2009/10 Quality Report should be included in the Trust's Annual Report 2009/10. Monitor has mandated that a state of readiness review should be undertaken on the 2009/10 Quality Report.

2.1 Project Scope and Objectives

The objectives of our review, as detailed in our engagement letter, are as follows:

- review and report on the arrangements the Foundation Trust Board has put in place to prepare and publish the Quality Report against Monitor's published set of criteria, in anticipation of providing a published reasonable assurance opinion in 2010/11;
- undertake sample testing of the systems to support the preparation of three mandated performance indicators, in anticipation of providing a published limited assurance opinion in 2010/11; and
- provide a report to the Trust Board of their findings and recommendations for improvements, in anticipation of a published audit opinion in the 2010/11 Quality Report.

The three mandated performance indicators that have been prescribed by Monitor are as follows:

- MRSA bacteraemia;
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers; and
- 18 weeks data.

2.2 Approach

Our approach to the review involved the following procedures:

- conducting interviews and information gathering with Executive Directors, Non Executive Directors and other key staff at the Trust. Appendix 1 provides the list of individuals that we interviewed as part of our review;
- reviewing relevant supporting documentation, such as policy documents, system data, relevant board, audit and governance committee reports, the results of relevant internal and external reviews and the other information and assurance evidence that sits behind the 2009/10 Quality Report and the data quality arrangements. Appendix B provides the list of documentation that we reviewed;
- documenting the data collection processes to produce the performance information against the mandatory indicators;
- walkthrough of the key activities and processes to produce the Quality Report;
- undertaking sample testing of the systems and controls to support the preparation of the three mandated performance indicators included in the 2009/10 Quality Report (MRSA; Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers; and 18 weeks data); and
- preparing, discussing, and issuing, after discussion of a draft, a report on our findings and recommendations for improvement for the 2010/11 Quality Report to the Trust Board and Board of Governors.

Through these activities our work sought to:

- review the arrangements that the Trust has in place to prepare and publish the Quality Report against Monitor's published set of criteria, under the headings: Governance and Leadership; Policies; Systems and Processes; People and Skills; and Data Use and Reporting;
- understand the data collection processes to produce the performance information against the mandatory indicators;
- understand the data quality checking processes to produce both internal and external performance information;
- test the systems and controls in respect of the mandatory indicators, on a sample basis, to gain assurance over the six dimensions of data quality:
    - Accuracy - Is data recorded correctly and is it in line with the methodology for calculation?
    - Validity – Has the data been produced in compliance with relevant requirements?

- Reliability – Has data been collected using a stable process in a consistent manner over a period of time?
- Timeliness - Is data captured as close to the associated event as possible and available for use within a reasonable time period?
- Relevance - Does all data used to generate the indicator meet eligibility requirements as defined by guidance?
- Completeness – Is all relevant information, as specified in the methodology, included in the calculation?

- review the findings and corresponding actions of any relevant internal /external reviews; and
- produce a report, containing areas for improvement and practical recommendations for the Trust to action in preparation for the 2010/11 Quality Report and external assurance requirements.

Our concluding assessments are based on the following ratings:

	No arrangements in place – significant improvements recommended
	Limited arrangements in place – improvements recommended
	Arrangements in place – no improvements recommended

3. Governance and Leadership

In this section, we are required to assess whether the body has put in place a corporate framework for management and accountability of data quality in relation to Quality performance, with a commitment to secure a culture of data quality throughout the organisation.

Key Component	Summary of Findings	Conclusion
1.1 There is clear corporate leadership of data quality by those charged with governance.	There is a governance structure in place at the Trust with reporting lines to the Trust Board. The Data Quality Group reviews data issues from across the Trust and reports up to the Information Governance Committee. There is an Information and Data Quality Policy which sets out responsibilities towards data quality across different Trust staff. There is an Information Governance Toolkit which includes information on policies, processes and procedures which feed into the Information Governance Committee. The Director of Governance and Corporate Affairs has led the Quality Report preparation.	
1.2 A senior individual at top management level (for example a member of the senior management team) has overall strategic responsibility for data quality, and this responsibility is not delegated.	The individual at top management who is responsible for data quality was the Director of Finance in 2009/10. We understand this has changed to the Interim Deputy Chief Executive for 2010/11.	
1.3 The corporate objectives for data quality are clearly defined (although this may not necessitate a discrete document for data quality), and have been agreed at top management level.	There is an Information and Data Quality Policy which sets out the Trust Board's objectives for data quality in clear terms.	

Key Component	Summary of Findings	Conclusion
1.4 The data quality objectives are linked to business objectives, cover all the body's activities, and have an associated delivery plan.	The Information and Data Quality Policy states *'the Board seeks to establish an information quality system with the fundamental objective of satisfying and maintaining prescribed standards of quality and integrity of information used in scheduling, delivering and transferring responsibility for health care within the Trust and with our care partners across care settings' and that 'Information quality must operate across all our activities. We will need to ensure that delivery of quality information is designed into current and future activities. We need to ensure that in decommissioning activities we do not destabilise information services to patients, significant others and our staff delivering health care*'. Thus, while not mapping directly to each of the business objectives of the Trust, the Policy clearly states that data quality must operate across all activities, which encompasses the business objectives.	
1.5 The commitment to data quality is communicated clearly, reinforcing the message that all staff have a responsibility for data quality.	There is a clear commitment to data quality at the Trust, demonstrated by the Information and Data Quality Policy. This includes designation of responsibilities to the Head of Performance and Information, plans to achieve level 3 across the board on the Information Governance Toolkit, and the focus of the Data Quality Group. In addition, individual people's job descriptions include data quality related requirements.	
1.6 Accountability for data quality is clearly defined and is considered where relevant as part of the performance appraisal system.	The appraisal process at the Trust incorporates review of individuals' performances against their specific job descriptions. Issues over their performance are highlighted, and addressed initially through training and support. As job descriptions throughout the Trust incorporate data quality related aspects, they are considered as part of the performance appraisal system.	

Key Component	Summary of Findings	Conclusion
1.7 There is a framework in place to monitor and review data quality, with robust scrutiny by those charged with governance. The programme is proportionate to risk.	The framework for monitoring and reviewing data quality at the Trust ultimately begins with the Information and Data Quality Policy, approved by Trust Board. This sets out the responsibilities for monitoring the quality of data and information, through the executive lead on Information Governance, the Information Governance Steering Group, and the Data Quality Group (which feeds up into the Information Governance Steering Group). It sets out the roles within this area of General Managers, Head of Booking and Choice, Head of Pharmacy, Data Warehouse Manager, Head of Performance and Information and Data Quality manager. During 2009/10 there have been monthly Performance Board meetings which included discussion of Data Quality. These meetings were chaired by the Chief Executive Officer and attended by clinical leads and management staff. We understand that these meetings have changed in 2010/11 to take place at a divisional level to reflect the change in structure at the Trust. Given the importance of the Trust having accurate information in order to make decisions about priorities for improvement, and to identify areas of concern or risk to patients, this structure is considered proportionate to risk.	
1.8 Data quality is embedded in risk management arrangements, with regular assessment of the risks associated with unreliable or inaccurate data.	A significant risk management arrangement at the Trust is the Assurance Framework. The Board are regularly updated on significant risks, mitigating actions taken and plans going forward. Data quality and other data related issues are highlighted as risks on the risk register, with key controls, details of where assurance comes from, and gaps in the controls or assurance evidenced. Risks are red, amber or green rated.	

Key Component	Summary of Findings	Conclusion
1.9 Where applicable, the body has taken action to address the results of previous internal and external reviews of data quality.	Primary reviews of data quality include internal audit reports, which in 2009/10 include 18 weeks, including data quality (substantial assurance) in May 2010 and Data Quality - income (adequate assurance) in January 2010. All Internal Audit recommendations are reported to Audit Committee, with management response. Implementation of planned actions are then monitored by the Audit Committee.	
1.10 Where there is joint working, there is an agreement covering data quality with partners (for example, in the form of a data sharing protocol, statement, or service level agreement).	The Trust signs up to the Inner North West London Health & Social Care Community inter Organisation Memorandum of Understanding for Sharing of Information - referred to as the Information Sharing Protocol.	
1.11 The narrative and supporting information in the Quality Report presents a balanced picture of the trust's performance. (in this context balanced means that the information is not just focussed on good performance but also covers performance which needs to be improved and that there is reasonable coverage of trust wide quality performance).	From a detailed review of the Quality Report for 2009/10, it is considered that there is a balanced view of the Trust's performance. Narrative in different sections includes details of what level the Trust is performing at, how that compares to target and national average, and what plans are in place to improve. There are also the statements from key stakeholder, in which the statement from Kensington & Chelsea Local Involvement Network is especially frank.	

Key Component	Summary of Findings	Conclusion
1.12 Clinicians have approved the data included in the Quality Report.	We understand that producing to the Quality Report was a very iterative process. Throughout the year there were quarterly updates with executive director leads and clinicians as appropriate, and the final Quality Report went through various levels of review by committees and individuals. The report to Audit Committee and Board prepared by the Director of Governance and Corporate Affairs regarding assurance over the 2009/10 quality account sets out the processes completed, which included each section of the report being allocated to an executive lead director to provide input; these were then reviewed by Director of Governance and Corporate Affairs and the clinical nurse specialist for ITU who was seconded to assist with the report. The Quality Report was discussed in the Clinical Governance Committee which is chaired by the Medical Director. Clinical Directors were invited to comment on the Quality Report and were encouraged to take the relevant sections of the Quality Report to their individual directorates for discussion.	

In the dry-run of external assurance guidance issued by Monitor in April 2010, there were a number of requirements for NHS Foundation Trusts to fulfil. These are shown in Appendix A.

We reviewed the section on preparing and publishing the Quality Report in the Statement on Internal Control in the 2009/10 published accounts, the Statement of Directors' Responsibilities in respect of the 2009/10 Quality Report and the paper explaining the arrangements for preparing and publishing the Quality Report against Monitor's guidance.

4. Policies

In this section we are required to assess whether the body has put in place appropriate policies or procedures to secure the quality of the data it records and uses for reporting in the Quality Report.

Key Component	Summary of Findings	Conclusion
2.1 There is comprehensive guidance for staff on data quality, translating the corporate commitment into practice. This may take the form of a policy, set of policies, or operational procedures, covering data collection, recording, analysis and reporting. The guidance has been implemented in all business areas.	The primary guidance on data quality requirements of the Trust is the Information and Data Quality Policy. This is translated into more usable guidance for staff through training around the key systems. Training is mandatory for all staff involved in the collection and management of patient data, and includes sections on how to ensure the correct data is recorded, and on correcting and reporting any errors identified.	
2.2 Policies and procedures meet the requirements of any relevant national standards, rules, definitions or guidance, for example the Data Protection Act, as well as defining local practices and monitoring arrangements.	We understand that the Trust has built the requirements of the Data Protection Act into its Information and Data Quality Policy, training programmes, information sharing protocol and monitoring processes. Information relevant to national targets set by the DH or Monitor are collected and reported. Local indicators have also been developed in key areas where no national indicator exists in order to provide information to the Trust for it to manage its own priorities.	

Key Component	Summary of Findings	Conclusion
2.3 Policies and procedures are reviewed periodically and updated when needed. The body is proactive in informing staff of any policy or procedure updates on a timely basis.	Policies and procedures are reviewed periodically and updated when needed. We have been provided with various examples of policies at the Trust, all of which include a start date and next review date. Updated policies are placed on the trust's intranet and highlighted when they are put there. Relevant divisional directors and managers are also charged with ensuring policy changes are communicated to their staff.	
2.4 All relevant staff have access to policies, guidance and support on data quality, and on the collection, recording, analysis, and reporting of data. Where possible this is supported by information systems.	Staff have access to all policies via the intranet. Through meetings specifically for the detailed testing on 18 Weeks and 62 Days, staff were able to explain key features of relevant policies, demonstrating awareness of them. The key Trust system is Lastword, the patient administration system. Some data is manually monitored and managed in Excel, outside of the Lastword system (i.e. 62 days data which is recorded on Infoflex and reported using Excel). Other information is entered into other systems which then interface with Lastword (such as Mysis, which the laboratory input test results of blood cultures for tests such as MRSA bacteraemia).	

Key Component	Summary of Findings	Conclusion
2.5 Policies, procedures and guidelines are applied consistently. Mechanisms are in place to check compliance in practice, and the results are reported to top management. Corrective action is taken where necessary.	Through meetings with Trust Executives and Non Executives, we were provided details of the information source, and views on any limitations within the data, for all indicators within the Quality Report. Corroborating the view that the data quality is sufficiently accurate, a review of the Data Quality Group minutes demonstrates that there have been discussions around particular issues which could adversely impact on data quality, such as missing RTT forms requiring retrospective completion, and the impact this could have on key indicators such as 18 weeks. The Group has discussed and developed data quality performance measures and mechanisms to alert operational managers to where problems are arising. However, the errors noted in our detailed testing documented in Section 8 indicated that mechanisms are not in place to check compliance in practice.	

5. Systems and Processes

In this section we are required to assess whether the body has put in place systems and processes which secure the quality of data underpinning the Quality Report as part of the normal business activity of the body.

Key Component	Summary of Findings	Conclusion
3.1 There are systems and processes in place for the collection, recording, analysis and reporting of data which are focused on securing data which are accurate, valid, reliable, timely, relevant and complete.	Data is collected from various sources and through multiple mechanisms across the Trust. Key data is captured and reported through the monthly performance reports compiled by the Head of Performance. The data within these reports comes from different places and systems, but behind each item is a responsible manager and team. Some are relatively straight forward, as the numbers of records involved or processes through which the data needs to go are relatively low. Others are complex, and have a large team of people involved in collating and managing the data. The over-arching Information and Data Quality policy applies across all areas, but the systems and processes are driven by the nature of each data stream.	
3.2 Systems and processes work according to the principle of right first time, rather than employing extensive data correction, cleansing or manipulation processes to produce the information required.	The Trust self assessed itself a high score in the Information Governance Toolkit self assessment. This was subsequently reviewed by Internal Audit in January 2010. Training documentation and policies include details on correcting errors or omissions which are identified, but also emphasise getting the information correct and validated to start with. However, errors identified in the detailed testing (see Section 8 for more details) indicate that this practice has not been embedded throughout the organisation. There are some processes in	

Key Component	Summary of Findings	Conclusion
	place to check information (such as the 18 week validation teams), but these are in place in order to validate data which imply the Trust has failed or is at risk of failing a target.	
3.3 Arrangements for collecting, recording and reporting data are integrated into the business planning and management processes of the body, supporting the day-to-day work of staff.	We have held meetings specifically to discuss the 18 weeks, 62 days and MRSA bacteraemia indicators. At each meeting we have met with key staff members involved in processing and managing data which feed into the indicator, and documented the processes and controls in place as they go through their tasks. For these specific areas data collection, recording and reporting arrangements are integrated into the business planning and management processes of the Trust. We understand that this is also the case with other information streams.	
3.4 Information systems have built-in controls to minimise the scope for human error or manipulation and prevent erroneous data entry, missing data, or unauthorised data changes. Controls are reviewed at least annually to ensure they are working effectively.	There are a number of information systems in use at the Trust. The primary patient administration system is Lastword, upon which all patient specific information should reside. For different purposes, other systems are also used (e.g. Infoflex for 62 days), including manual use of Excel spreadsheets. In many cases, we understand that the systems for reporting national indicators involve manual reconciliation and manipulation of data, which could again be open to human error. These processes all have some degree of review as a control mechanism. However, greater risk exists at the points at which manually recorded information (such as RTT forms, clinical outcome forms, and GP referrals received etc) come onto the systems. Due to the quantity of these forms, we understand that once these are updated onto Lastword, they are destroyed. We understand that procedures exist to ensure the forms are completed and recorded on the system, but on occasion they may not be appropriately completed or completed at all, and this would be identified through end of day reconciliations for the 18 week indicator and a manual monitoring process for the 62 day	

Key Component	Summary of Findings	Conclusion
	indicator. However, there is no check that the clinician has recorded the correct information on the form, or that the data processor has correctly updated Lastword with the details which have been recorded on the form.	
3.5 Corporate security and recovery arrangements are in place. The body regularly tests its business critical systems to ensure that processes are secure, and results are reported to top management.	Data security is an issue which is taken very seriously by the Trust, with all policies and procedures relating to data quality and recording reminding the reader of their obligations under the Data Protection Act. Recovery arrangements are also recognised as vital, as so many Trust processes require the support of IT infrastructure and applications. The Information Governance Toolkit has specific criteria relating to information security (criteria 206, 210 and 303). There are also specific criteria regarding recovery arrangements (criteria 310). The Trust has self assessed itself as performing at level 3 against all of these criteria, and internal audit have verified that there is evidence to support this level of performance.	

Based on our findings above, we have made 3 recommendations. Please refer to Section 10 recommendations 1 to 3 for the details and for management's response.

6. People and Skills

In this section we are required to assess whether the body has put in place arrangements to ensure that staff have the knowledge, competencies and capacity for their roles in relation to data quality underpinning the Quality Report.

Key Component	Summary of Findings	Conclusion
4.1 Roles and responsibilities in relation to data quality are clearly defined and documented, and incorporated where appropriate into job descriptions.	The Information and Data Quality policy has a 'Responsibilities' section which lists the responsibilities of key individuals involved in data quality. The various job descriptions reviewed all include points relating to data quality.	
4.2 There is a programme of training for data quality, tailored to needs. This includes regular updates for staff to ensure that changes in data quality procedures are disseminated and acted on.	There is a range of training in relation to data quality. Training is tailored to the needs of the staff attending, usually driven by their role and by the information systems which they will be using. The Information and Data Quality Policy includes in the responsibility section a requirement for management in various parts of the organisation to determine the training needs in respect of data capture of their staff. Through this mechanism, training and updates are disseminated.	

Key Component	Summary of Findings	Conclusion
4.3 The body has put in place and trained the necessary staff, ensuring they have the capacity and skills for the effective collection, recording, analysis and reporting of data.	With regard to the three indicators on which detailed work is being performed, we have held meetings with key staff involved in the data capture and reporting processes. From our understanding of the processes involved and through our testing, we consider that the Trust has put in place and trained the necessary staff as described. However, there have been instances where the detailed testing has identified issues within the data recorded (see Section 8). We understand from meetings we have attended that other areas of data collection and reporting are considered to be appropriately staffed.	
4.4 There are corporate arrangements in place to ensure that training provision is periodically evaluated and adapted to respond to changing needs.	The Information and Data Governance policy describes how managers in various roles are responsible for determining the training needs of their staff in relation to data quality. It also explains the Information Toolkit level 3 requirements, which includes at item 509 '*The Trust has (or accesses) a formal targeted programme for all staff involved in the collection and management of patient related data on all key systems and this is maintained and its effectiveness routinely audited*.' The Trust self assessed as passing this criteria. We have also seen evidence of various data quality training, and minutes from the Information Governance Committee which includes evidence around updating data quality training.	
4.5 Staff collecting, recording, analysing and reporting data are assessed on their adherence to the data quality standards set by the Trust.	There is an appraisal process in operation at the Trust, through which individuals are appraised against their own objectives as well as corporate objectives. Their individual objectives are informed by their job role and job description. The Quality Report includes a statement that in 2009, the staff survey showed that 76% of staff had an appraisal in the previous 12 months. This is explained as being one of the highest rates of any acute Trust; however it is considered that there is room for improvement and a recommendation has been raised on this point.	

Key Component	Summary of Findings	Conclusion
4.6 Arrangements are in place to ensure the foundation trusts' data quality standards are adhered to when using temporary staff (agency or locums) for collecting data.	There is an induction policy in force at the Trust which covers all staff, regardless of whether they are temporary, agency, full time, part time, locums etc. For temporary staff, the policy dictates that all wards and departments will have written procedures for inducting these temporary staff, and the local line manager is to ensure that all temporary staff are adequately inducted into the unit, whether they are working for just one day or a longer period of time. There are a number of minimum requirements, one of which is that key local policies and procedures must be provided and read. Staff collecting, recording, analysing and reporting data on a temporary basis should therefore have the Information and Data Quality related policies and procedures.	

Based on our findings above, we have made 1 recommendation. Please refer to Section 10 recommendation 4 for the details and for management's response.

7. Data Use and Reporting

In this section we are required to assess whether the body has put in place arrangements that are focused on ensuring that data supporting reported Quality information is actively used in the decision making process, and is subject to a system of internal control and validation.

Key Component	Summary of Findings	Conclusion
5.1 Internal and external reporting requirements have been critically assessed. Data provision is reviewed regularly to ensure it is aligned to these needs.	Primary internal reporting of performance indicators is through the monthly performance reports to the board. There has been a review of the format and content of these reports for 2010/11 based on the revised spread of national and local indicators requiring board attention. This review was led by the executive lead for information governance and has led to reports with more graphic performance dashboards to highlight problem areas more easily. External reporting requirements are placed on the Trust by various organisations, including Monitor and the DH. Requirements are understood, where appropriate the information will be included in performance reporting to the board, and information will be captured as necessary to meet the external reporting requirements.	
5.2 Data used for reporting to those charged with governance are also used for day-to-day management of the body's business. As a minimum, reported data, and the way they are used, are fed back to those who create them to reinforce understanding of their wider role and importance.	We understand from meetings we have held that information reported to the board on a monthly basis is used more frequently for day to day management of the Trust's operations.	

Key Component	Summary of Findings	Conclusion
5.3 Data is used appropriately to support the levels of reporting and decision making needed (for example, forecasting achievement, monitoring service delivery and outcomes, and identifying corrective actions). There is evidence that management action is taken to address service delivery issues identified by reporting.	The primary reporting of data in relation to performance indicators is through the monthly performance reports to the Board. These demonstrate active use of information and describe management decisions in order to manage the achievement of targets where patient care is involved. Through meetings which we have held, we also understand that it is through a review of reported information regarding complaints and dealing with them that an objective has been brought in around admissions and appointments. The priority around patient falls was added after a review of incidents. These are further examples of data supporting decision making and corrective actions.	
5.4 Data which are used for external reporting are subject to rigorous verification e.g. internal audit, clinical audit, or checks in local health economy, and to senior management approval.	There are various processes by which data used for external reporting are subject to verification - both internal and external. Internal audit have performed reviews over certain key areas in the year, including 18 weeks (January and May 2010) and the responses to the Information Governance Toolkit (January 2010). During 2009/10 we understand that there was a push to have clinicians 'own' their 18 week breaches to give additional assurance that the breach was valid. Clinical audits have taken place in a number of areas; however we understand that the number of clinical audits actually undertaken is considered to be under-reported within the Trust, and management may not be fully aware of the clinical audits undertaken. Challenge processes are an option open to PCTs throughout the year, and other scrutiny exists from governors etc. In addition to this, there are internal procedures to validate much of the information which is externally reported.	

Key Component	Summary of Findings	Conclusion
5.5 All data returns are prepared and submitted on a timely basis, and are supported by a clear and complete audit trail.	From our detailed testing of the three mandated indicators, we have had difficulty tracing back from the reported information to the source data on the Trust's systems for the 62 days and 18 week indicators. We understand from discussion with staff that there may be issues over other indicators (e.g. 26 weeks) in the Quality Report being consistent with recorded information. A recommendation around this has been raised.	
5.6 Where appropriate there is evidence of data being triangulated against other sources of information such as patient feedback.	We understand that as data is reported through the governance structure up to those charged with governance, and there are examples of triangulation with other sources of information such as patient feedback. Patient complaints are a key part of this triangulation, with issues raised in complaints being considered alongside indicators to identify whether issues are likely to be one offs, or a sign of a bigger issue. Patient governors also form an important part of the patient feedback process. During the year they raised an issue over patient discharges and delays in the process. This is now being considered as a priority for dealing with, and will most likely make it into next year's Quality Account.	
5.7 Clinical data is reported at Board level, with evidence of Board challenge in response.	Board minutes evidence a number of discussions around clinical data. The particular minutes reviewed also include discussion the Mid Staffs incidents and the subsequent report which had been issued. In the ensuing debate, the board appear very open to the reasons behind the issues at Mid Staffs, how they arose, and what was needed in order to prevent a similar occurrence at Chelsea & Westminster.	

Based on our findings above, we have made 1 recommendation. Please refer to Section 10 recommendation 5 for the details and for management's response.

8. Data Testing of Three Mandated Performance Indicators

The three mandated performance indicators that have been prescribed by Monitor for testing are as follows:

- MRSA;
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers; and
- 18 weeks data.

The procedures we performed did not constitute a review or an audit of any kind. We did not subject the information contained in our Report or given to us by the Directors to checking or verification procedures except to the extent expressly stated below. This is normal practice when carrying out such limited scope procedures, but contrasts significantly with, for example, an audit. The procedures we performed were not designed to and are not likely to reveal fraud. We have not performed any tests over the completeness or summarisation of reports provided to us by management.

8.1 MRSA Bacteraemia

The 2009/10 NHS Operating Framework and the 2007 Public Service Agreement 'Ensure better care for all' sets out the target of maintaining the national annual number of MRSA bloodstream infections at less than half the national number in 2003/04. MRSA bacteraemia are attributed to either the Trust (48 hour post admission) or the Community (less than 48 hour post admission). During 2009/10, the Trust reported 10 cases of MRSA bacteraemia.

Approach	Results
We discussed with the MRSA team the process of recording the MRSA data in the Quality Report. The Trust provided us with a summary report showing the 10 MRSA bacteraemia cases for the 12 months ended 31 March 2010. All 10 patients were selected for testing and we conducted the	The results of our testing noted the following: i) The Trust was unable to evidence MRSA admission date, test date and test result date on Lastword for 1 patient. As supporting data for this patient was not available on Lastword we have been unable to complete all of the tests on this patient;

Approach	Results
following tests: • Agreed admission date, test date and test result date to the Lastword system; • Agreed test date and test result date to the Mysis system; • Discussion with the MRSA team indicated that the two systems, Lastword and Mysis (laboratory system), directly interface. We have compared the data on the two systems; • Confirmed a positive MRSA test result to the Mysis system; • Agreed the results of the 10 cases to the MESS return; and • Checked completeness by reviewing a report showing all blood culture results for the year ended 31 March 2010 to confirm there were only 10 positive results.	We have not made any recommendations specifically in relation to the MRSA process, as the issue identified is covered by recommendations raised in other areas. In particular, recommendation 5 is considered pertinent around supporting evidence.

8.2 Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

From January 2009, the operational standard (as per the Cancer Reform Strategy) is that 85% of patients referred by urgent GP referral should receive first treatment within 62 days. This relates to all cancers. During 2009/10, the Trust reported 93.01%.

Approach	Results
We discussed with the 62 day team the process of producing a report to enable our sample to be selected and agreed that a report covering 6 months of the year would be sufficient; the Trust provided us with a report showing 62 day patients for the 6 months ended 31 March 2010. 25 patients were selected at random from a population based on patient pathways completed in the last 6 months of the year ended 31 March 2010. The sample was tested as follows: • Start dates were agreed to referral documentation from the patient files and the validity of the start date was confirmed with reference to the guidance on the 62 day indicator. • Clinician forms are not kept permanently by the Trust. As some reliance by the Trust is placed on the input of the clinician forms onto the Lastword system, we have tested 25 clinician forms to check agreement back to the Lastword and Infoflex systems. • Stop dates were agreed to supporting documentation (e.g. operation notes) from the patient files and the validity of the stop date was tested with reference to	The results of our testing noted the following: i) We have reconciled the sample data for the 6 months provided by the Trust back to the indicator of 93.01% included in the Quality Report, differences on individual patients were noted as documented in point v; however, an overall difference in the percentage was also noted. Information provided by the Trust to support the percentage in the Quality Report indicated a result of 93.12% but this does not cause the Trust to breach its overall target. ii) Supporting information to enable confirmation of the referral receipt/clock start date was not included within 2 sets of patient's notes. As information for these patients was not complete it has not been possible to verify the clock duration has been recorded correctly for these patients; iii) Supporting information to enable confirmation of the date of treatment/clock stop date was not included within 4 sets of patient notes. As information for these patients was not complete it has not been possible to verify the clock duration has been recorded correctly for these patients; iv) In addition to the findings in point ii, the clock stop date noted on Infoflex did not agree to the treatment information included within the patient notes for 3 patients. These differences had no effect on overall outcome of each patient (i.e. breach or no breach);

Approach	Results
the guidance on the 62 day indicator. • No adjustments were noted on the sample of 25 patients selected for testing. • The clock duration was recalculated and the result for each patient was agreed to the monthly reports which are provided to the Performance team. These reports were reconciled to the indicator that was included in the Quality Report. • Completeness of the indicator has been checked by sampling both breaches and non breaches and as part of the agreement of the individual cases back to the Quality Report as this involved checking cases which were not in the original sample.	v) Information in relation to 6 patients was not correctly recorded on the monthly report provided to the Performance team. These exceptions will have an impact on the percentage recorded in the Quality Report. We have confirmed that 1 error has a negative impact and 3 errors have a positive impact on the Quality Report but we have been unable to confirm the impact of the remaining 2 errors as supporting documentation was not available for these patients; **Testing of Clinical Outcome Forms** The codes on 16 clinical outcome forms had not been correctly input onto Lastword. However, ultimately the information for the 62 day indicator in the Quality Report is taken from the Infoflex system. A check to Infoflex identified that there were differences between the clinical outcome forms and Infoflex on 2 patients. The reason for this is that the Multi disciplinary team co-ordinators use additional sources other than Lastword when updating Infoflex. Due to the variety of sources that the MDT co-ordinators use we have been unable to verify the impact of this issue on the % reported in the Quality Report. We have made 5 recommendations in relation to the 62 day process; see the Action Plan in Section 10 recommendations 8 to 12.

8.3 18 weeks referral to treatment pathway ("RTT")

There are two 18 weeks RTT patient pathways: admitted and non-admitted. The operational standards of delivery are:

- 90% of pathways where patients are admitted for hospital treatment should be completed within 18 weeks (Admitted RTT Pathway); and
- 95% of pathways that do not end in an admission should be completed within 18 weeks (Non Admitted RTT Pathway).

During 2009/10, the Trust reported 93.40% (Admitted RTT Pathway) and 98.97% (Non Admitted RTT Pathway).

Approach	Results
We discussed with the 18 week team the process of producing a report to enable our sample to be selected and agreed that a report covering the general surgery and cardiology specialties for the 12 months ended 31 March 2010 would be sufficient. The Trust provided us with a report split between admitted and non-admitted and showing clock duration. 25 patients were selected from the population. The population was pro-rated between admitted, non-admitted and between the two specialities as follows and was tested as follows: • **Sample sizes:** Admitted general surgery – 6 Admitted cardiology – 1 Non-admitted general surgery – 11 Non-admitted cardiology – 7 • Start dates were agreed to referral documentation from the patient files and the validity of the start date was confirmed with reference to the guidance on the 18	The results of our testing noted the following: **Both pathways** i) The data provided by the information team from the system from which the population was selected did not reconcile to the indicator recorded in the Quality Report: Non-admitted pathway – Quality Report indicates 98.97% compared to the population data of 98.75%. Admitted pathway – Quality Report indicates 93.40% compared to the population data of 93.22%. These differences do not cause the Trust to breach its overall target and, if the Trust had used whole integers in the Quality Report this would not have been identified as an issue. We have discussed these differences with the Information team who provide the information for the Quality Report. This team has indicated the differences are due to: a) Information in the Quality Report is based on the information that was sent to the Board early on in the month. At this point in time the validation was ongoing and changes were still being made to pathway results;

Approach	Results
week indicator. • RTT forms are not kept permanently by the Trust. As some reliance by the Trust is placed on the input of the RTTs onto the Lastword system, we have tested 25 RTTs to check agreement back to the Lastword systems. • Stop dates were agreed to supporting documentation (e.g. operation notes) from the patient files and the validity of the stop date was tested by agreement to Lastword and with reference to the guidance on the 18 week indicator. • Adjustments were agreed to supporting documentation such as patient notes and recalculated. • The clock duration was recalculated and the result for each patient was agreed to a report produced by the Information team who provide the information to be included within the Quality Report. This report was reconciled to the indicator that was included in the Quality Report. • Completeness of the indicator has been checked by observing the parameters input for the sample data when it was run and ensuring that no alterations to the sample data spreadsheet were made. We have also checked one month's worth of completeness submissions to the Department of Health which provide a comparison of the number of expected completed pathways that are reported by the Trust to	b) We understand that one reason for this difference is that we have been provided with information to support the Unify submission rather than the Quality Report. Although the Quality Report and Unify submission should report the same indicator, we understand that differences exist due to the way that the information is extracted from the system. Information for the Quality Report was extracted from the system using certain formulae which are based on Local Specialty codes. The percentage recorded in the Trust's Unify submission was extracted from the system using slightly different formulae based on mapping to National Treatment Function Codes. This formulae difference inevitably results in discrepancy between the indicator recorded in the Quality Report and the indicator reported to Unify. We have not raised a recommendation in relation to this point as it has already been documented in our recommendation for the arrangements around 'Data Use and Reporting'. c) For the non-admitted pathway only, GUM patients are maintained on a separate system to Lastword and the information from the two systems is required to be merged in order to report a final figure to the Board. This 'merging' process was forgotten and therefore the GUM patients were omitted from the Board report. **Non-admitted pathway – total sample of 18** i) Supporting information to enable confirmation of the referral receipt/clock start date was not included within 3 sets of patient's notes (including patient in point viii). As information for these patients was not complete it has not been possible to verify the clock duration has been recorded correctly for these patients; ii) In addition to the findings in point i, we were not able to verify the clock start date for 6 patients as the referral information included within patient notes had not been date stamped on receipt. As information for these patients was not complete it has not been possible to verify the clock duration has been recorded correctly for these

Approach	Results
what the Trust actually reported. This would identify if the Trust were under or over reporting pathways.	patients; iii) The performance team use an algorithm based tool to analyse information for this indicator. There is a 'bug' in this tool which results in the spreadsheet tool always taking the first referral date of a patient ("freeze date issue"). The effect of this is that, for patients with multiple pathways, manual validation of the start date is required to check the correct referral date has been used. An error as a result of this was noted in relation to 1 patient. Currently this patient is recorded as breaching on 1 pathway. Information we were provided with indicated this patient should have 2 pathways with only 1 breaching. However, as support for the referral date was not available we have not been able to confirm this result; iv) Supporting information to enable confirmation of the date of treatment/clock stop date was not included within 3 sets of patient notes (including patient in point viii). As information for these patients was not complete it has not been possible to verify the clock duration has been recorded correctly for these patients; v) In addition to the findings in point iv, the clock stop date noted on Lastword did not agree to the treatment information included within the patient notes for 4 patients. We have been unable to verify if this would have resulted in a change in the overall outcome (i.e. breach or no breach) for 2 of the patients as the Trust was not able to provide support for start dates (point i). Of the remaining 2 patients, 1 of these clock stop differences would have resulted in a non breach changing to a breach; vi) In 1 patient case the clock duration had not taken account of a 'pause' on the patient's clock. We understand from discussion with the Performance team that non-admitted patients do not tend to have pauses and therefore the spreadsheets are not set up to account for these. The patient in question was initially due to have surgery which would have put them on the admitted pathway but this treatment decision was altered resulting on the patient appearing on the non-admitted pathway. We have been unable to verify if this would have resulted in a change in the overall outcome (i.e. breach or no breach) as the Trust was not able to provide support for start dates

Approach	Results
	(point i); vii) An issue was noted with 1 patient which suggested that manual validation of the patient's pathway altered the patient's details incorrectly. This resulted in a breach being recorded as a non breach by the Trust; and viii) Information provided for 1 patient included within the indicator suggested that the patient was referred to surgical appliances. This patient was recorded as a 'non breach' but, as surgical appliances is not a consultant led specialty, the 'non breach' should not have been included on the 18 week pathway. **Admitted pathway – total sample of 7** i) Supporting information to enable confirmation of the referral receipt/clock start date was not included within 2 sets of patient's notes. As information for these patients was not complete it has not been possible to verify the clock duration has been recorded correctly for these patients; ii) In addition to the findings in point i, we were not able to verify the clock start date for 1 patient as the referral information included within the patient notes had not been date stamped on receipt. As information for this patient was not complete it has not been possible to verify the clock duration has been recorded correctly for this patient; iii) The freeze date issue was noted on 1 patient. This patient was recorded as 1 pathway with duration of 531 days. Information from the Lastword system indicated this patient should have 2 pathways with only 1 breaching. However, we have been unable to verify this as the Trust was not able to provide supporting documentation for the clock start or stop dates; iv) Supporting information to enable confirmation of the date of treatment/clock stop date was not included within 1 set of patient notes. As information for this patient was not complete it has not been possible to verify the clock duration has been recorded

Approach	Results
	correctly; v) Testing on 1 patient identified a difference in the duration of the clock between Lastword and the sample data of 4 days. The Trust was not able to provide an explanation for this. We have made 4 recommendations in relation to the 18 week process; these are included in the Action Plan in Section 10 recommendations 13 to 16.

9. Statement of Responsibility

We take responsibility for this report, which is prepared based on the limitations set out below.

Deloitte LLP

15 October 2010

Deleted: 02 September 2010

Deleted: 01 September 2010

Contact Persons

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Manager: Zoe Prescott

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Our report is prepared solely for the confidential use of the Chelsea & Westminster Hospital NHS Foundation Trust and solely for the purpose of supporting of the dry-run of external assurance on the 2009/10 Quality Report and may not be relied upon by the Trust for any other purpose whatsoever. We agree that a copy of our report may be provided to Monitor for their information in connection with this purpose but, as made clear in our engagement letter dated 7 June 2010, only on the basis that we accept no duty, liability or responsibility to Monitor in relation to our Deliverables. Our report must not be recited or referred to in whole or in part in any other published document without our written permission. Our report must not be made available, copied or recited to any other party without our express written permission in every case except for Monitor may disclose the report where it has a statutory obligation to do so. Other than to the Trust we neither owe nor accept any duty to any other party to whom this report may be disclosed.

This report does not constitute a formal opinion over the arrangements in place within the Foundation Trust to prepare and publish the Quality Report nor over the underlying data quality of the three mandated performance indicators. Instead it outlines a series of recommendations that the Trust should implement in anticipation of a published audit opinion in 2010/11 Quality Report. The matters raised in this report are only those which came to our attention during the course of our work and are not necessarily a comprehensive statement of all the weaknesses that may exist or all improvements that might be made. Any recommendations for improvements should be assessed by you for their full impact before they are implemented.

10. Action Plan for Recommendations

Ref	Page	Area	Recommendation	Priority	Lead	Management Response	Timescale
1	22	Systems and processes	On the 18 week and 62 day indicators there is reliance by the Trust on manual processes, for example reliance on the correct recording of the RTT and clinical outcome forms at the input stage of the process. Another example of manual processes is during the validation stage of the 18 week process due to exceptions caused by the 'freeze date issue'. To minimise the potential for human error or manipulation in the process, effort should be made to ensure that wherever possible, system controls assist with data validation, ensuring the correct recording of data from the point of entry.	High	Head of Performance Improvement	The 'RTT The Way Forward' project which is due to be completed early next year, will improve data quality in a number of ways. This includes improving ease of data entry and improving the accuracy with which the system measures the patient pathway. This should substantially reduce the requirement for validation. Data quality should also be improved by the data quality training being given to relevant administrative staff by the Data quality Manager.	March 2011

Ref	Page	Area	Recommendation	Priority	Lead	Management Response	Timescale
2	22	Systems and processes	Where manual spreadsheets are used, there should be a review process to ensure human error does not impact on reported information. The review process should be proportionate and risk based. For example, within the 62 day process a manually populated Excel spreadsheet is provided to the Information Team at the Trust for monthly reporting. Our detailed testing identified errors on the data in this spreadsheet.	High	Head of Performance Improvement	Guidance for staff who submit data to be developed including the need for accuracy, validity, reliability, relevance, completeness, and timeliness. Each area will be responsible for implementing the guidance and be accountable for the quality of data. To be monitored through the Divisional Finance and Performance Review meetings.	TBC
3	22	Systems and processes	The process for recording the 18 week and 62 day indicators places much reliance on the information recorded in the RTT and clinical outcome forms. A sample of RTT and other clinical forms should be retained on a periodic basis (daily / weekly) for all individuals inputting data from them in order for line managers to review the data recorded against the original forms. This should also incorporate some degree of challenge where events along a patient pathway do not appear logical to ensure appropriate information is recorded on the RTT or clinical forms in the first place.	Med	Director of Operations/ Head of Performance Improvement	Agree. A monthly sample of forms will be audited. To investigate whether it is possible to have an automated way of pulling illogical pathway samples for clinicians to review.	October 2010 October 2010

Ref	Page	Area	Recommendation	Priority	Lead	Management Response	Timescale
4	25	People and skills	Through its HR department, the Trust should validate the staff survey response that 76% of staff have had an appraisal in the last 12 months. We understand that efforts have been made by the Trust in 2009/10 to raise the profile of staff appraisals but recommend that a plan be put in place to ensure that all staff receive an appraisal at least every 12 months.	Med	Director of Human Resources	This is already in place. The HR dept. validates the staff survey response via its monthly appraisal tracker. Considerable efforts have been made to raise the profile of appraisals including an agreed policy, revised and simpler processes and monthly tracking. There is a plan to ensure staff receive an appraisal at least every 12 months and this is one of the Trust corporate objectives.	In place
5	29	Data use and reporting	For all reported indicators, there should be a record of how the information recorded by the Trust reconciles to the Quality Report and nationally submitted data. Where information is subject to a reconciliation process, this should be reviewed by management, evidenced as such, and retained in the manner of other audit working papers.	Med	Head of Performance Improvement	Agree. Will be implemented for the next report.	Next report
6	7	Detailed testing – non specific indicator	Figures for inclusion in the Quality Report should be taken from data once the validation process is complete and should be reconciled back to supporting documentation; reconciliations, including a check that the GUM patients have been included, should be reviewed by management and signed to indicate that this process has taken place.	Med	Head of Performance Improvement	Agree. Will be implemented for the next report.	Next report

Ref	Page	Area	Recommendation	Priority	Lead	Management Response	Timescale
7	7	Detailed testing – non specific indicator	The differences on the % recorded in the Quality Report in comparison to the population data provided would not have been an issue if the Trust had reported the indicator to nil decimal places in line with the presentation of the target indicator. We recommend that the Trust bring reporting on the individual indicators in line with the presentation of the target.	Med	Director of Governance and Corporate Affairs	Agree. Will be implemented for the next report.	Next report
8	32	Detailed testing – 62 days	To allow the Trust to document an audit trail, as recommended in the Cancer Reform Strategy (2007), 'End of treatment' summary sheets should be produced for each patient on the 62 day pathway and signed by a member of the clinical team.	Med	Cancer Manager	Agree – will develop with cancer clinical specialist team. The aim would be that the information is of clinical use and informative for the patient.	November 2010
9	32	Detailed testing – 62 days	Our review of documentation indicated that the clinical outcome proformas were updated in the year. Our testing of these documents indicated that 2 different layout of forms were being used. Effort should be made to ensure that 1 clinical outcome proforma is used which contains information on the effect on the clock of each code.	Med	Cancer Manager	The cancer MDT proforma has been changed recently to ensure capture of further data as required by Thames Cancer Registry. We will at times need to update but will ensure that there is improved version control. Also, the forms will differ necessarily between tumour sites.	Complete

Ref	Page	Area	Recommendation	Priority	Lead	Management Response	Timescale
10	32	Detailed testing – 62 days	To check that patients are being correctly recorded on the monthly report provided to the performance team, on a quarterly basis a sample of results for each specialty should be validated.	Med	Cancer Manager	Agree – refreshing data can lead to a difference in the numbers. Now have agreed timelines for data to be completed and sent to performance.	From Q2 2010
11	32	Detailed testing – 62 days	To assist staff with tracking of patient information, procedures for defining and categorising types of cancer should be clarified and communicated to all staff involved in the process.	Med	Cancer Manager	Agree – CG and the MDT coordinators to agree categorisation of cancers to ensure consistency of recording.	November 2010
12	32	Detailed testing – 62 days	To allow the Trust to document a complete audit trail, effort should be made to ensure that, where treatment takes place at other organisations, documentation confirming clock start and stops dates is obtained and retained on the patient file.	Med	Cancer Manager	Agree – End of treatment summary to be developed as point 10 and copy filed in patient notes.	November 2010
13	34	Detailed testing – 18 weeks	To assist in capturing all clock stops, consultants should be encouraged to fill out a referral to treatment ("RTT") form (NB an RTT form captures the result of the clinicians appointment and includes detail on the coding to be input onto Lastword) for patients who do require clock stops even if no follow up appointment is required.	Med	Director of Operations	Agree – we believe this is already in place – the audit did not demonstrate that outcome forms were not being completed for all patients. Performance is monitored weekly at consultant level	In place

Ref	Page	Area	Recommendation	Priority	Lead	Management Response	Timescale
14	34	Detailed testing – 18 weeks	To assist in minimising errors by the clinicians on coding of the RTT forms, effort should be made to emphasise the importance of the RTT form in capturing information for the 18 week pathway.	Med	Director of Operations	Agree – we believe this is in place. We have embarked upon a review of all RTT forms in the last year with clinician involvement to improve the outcome data quality at specialty level. All junior doctors also have 18 week training as part of their induction. The sample report of illogical pathway samples identified in recommendation 4 will also assist with checking quality	In place Oct 2010
15	34	Detailed testing – 18 weeks	To reduce the errors on start date caused by the 'freeze date issue' weekly validation information and all reporting on clock stops should be moved to the patient target/waiting lists spreadsheets known as the "pathway PTL" which is purely based on pathway identifications from 1 August 2009 and looks at the last RTT outcome, next planned activity and whether this will cause a breach.	Med	Head of Performance Improvement	TBC	TBC
16	34	Detailed testing – 18 weeks	To check that patients clocks have been stopped correctly, validation checks should be extended to patients whose clocks have been stopped to confirm that these patients have been treated correctly on the system rather than just focussing on clocks that are about to breach.	Med	Director of Operations/ Head of Performance Improvement	A sample of unvalidated clock stops will be validated on a monthly basis	Sept 2010

Appendix A: Requirements of the Trust

We have set out below a summary of the current requirements of NHS Foundation Trusts in respect of the Quality Report as per the Monitor guidance issued April 2010:

The dry run of proposals (or state of readiness review) for the 2009/10 Quality Reports for NHS Foundation Trusts required them to:

- include a brief description of key controls in place to prepare and publish a Quality Report in the Statement on Internal Control in the 2009/10 published accounts;
- sign a proforma Statement of Directors' Responsibilities in respect of the 2009/10 Quality Report (this is not required to be published in the 2009/10 Quality Report);
- provide the auditors with a paper which explains the arrangements the Trust has in place to prepare and publish the Quality Report against Monitor's guidance; and
- submit a copy of the auditors' report on the outcome of the dry run to Monitor and to the Trust's board of governors.

Appendix B –List of Interviewees

The staff, interviewed as part of this review, are listed below:

Arrangements Review

- Lorraine Bewes, Finance Director
- Cathy Mooney, Governance and Corporate Affairs
- Therese Davies, Interim Director of Nursing
- Heather Lawrence, Chief Executive
- Andrew Havery, Non Executive Director and Audit Committee Chair
- Doctor Mike Anderson, Medical Director and Chair of Governors/Quality Committee
- Charlie Wilson, None Executive Director and Chair of Assurance Committee
- Stuart Johnstone, Head of Performance Improvement for the year ended 31 March 2010
- Jovin Synott, Information Manager

MRSA

- Doctor Berge Azadian, Director of Infection Prevention and Control
- Roz Wallis, Lead Infection Control Nurse

18 Weeks

- Hannah Coffey, Divisional Director of Operations, Medicine and Surgery (Lead for 18 weeks)
- Simon Price, Out patients receptionist for General Surgery
- Gary Bellars, Appointments Office Manager
- Ish Rasool, Outpatients Service Manager
- Mike Delahunty, Head of Booking and Outpatients Services
- Louise Galloway, Surgical Admissions Manager
- Joanna Lutkin, Service Manager Children and Young People
- Sarah Buckland, Performance Manager Medicine

62 Days

- Catherine Gillespie, General Manager for Cancer
- Mark Bower, Clinical Lead for Cancer
- Victoria Keeble, Multi-disciplinary team co-ordinator (skin)
- Victoria Taplin, Multi-disciplinary team co-ordinator (urology)
- Claire Fauconier, Multi-disciplinary team co-ordinator (gynaecology)

IT

- Bill Gordon

Appendix C – List of Documentation

The documentation reviewed is listed below:

- 2009/10 Quality Report
- Various Assurance Committee meeting minutes
- Various Audit Committee meeting minutes
- Report on cancer waiting times reporting process dated 11 June 2010
- Various Data Quality meeting minutes
- Various Information Governance meeting minutes
- Various documents on Information Governance training
- Various job descriptions
- Various document on Lastword training
- Various performance reports
- Various policy manuals
- Various Quality Sub-Committee meeting minutes
- Various Risk Management Committee meeting minutes
- Various documents on tool-kit scores
- Executive briefings on 18 weeks
- Various guidance documents on 18 weeks
- Council of Governors quality paper dated April 2010
- Assurance Framework and Review of Corporate Objectives Q4 Report
- Infection control annual report
- Board paper on Draft Quality Improvement Plan dated 29/04/2010
- Board paper on Quality Report (Accounts) Assurance dated 27/05/2010
- Various Board of Directors meeting minutes
- Various Council of Governors meeting minutes
- Various documents on Data Quality training
- Cancer Reform Strategy letter dated 9 September 2009
- Various guidance documents on 62 days
- Various guidance documents on MRSA
- Diagram showing the governance structure in August 2009 and draft governance structure in June 2010
- Information Governance Toolkit Action Plan
- Information Governance Toolkit Assessment
- Quarter 4 return to Monitor
- Quality Report (From 2008/09 Annual Report)
- Various terms of reference for Boards/Committees
- Statement of Directors Responsibilities in respect of Quality Accounts
- Example staff surveys
- Example volunteer questionnaire

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Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 16 September 2010

AGENDA ITEM NO.	2.6/Sep/10
PAPER	Appointment of a new Non-Executive Director – Recommendation from the Nominations Committee
AUTHOR	Vida Djelic, Interim FT Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper outlines the process the Nominations Committee undertook when selecting a Non-Executive Director.
DECISION/ ACTION	The Council of Governors is asked to note update on the progress.

1.0 Introduction

The Nominations Committee is a Standing Committee of the Council of Governors which facilitates the appointment of Non-Executive Directors by the Council of Governors.

2.0 Background

The Terms of Reference of the Nominations Committee were approved by the Council of Governors.

The Nominations Committee has identified appropriate candidates through a process of open competition which took account of the policy maintained by the Council of Governors and the skills and experience identified by the Board of Directors, in accordance with the constitution and Code of Governance.

The Nominations Committee will make recommendations for appointment of a successful candidate to the Council of Governors.

3.0 Nominations Committee

The Nominations Committee comprises of Governors Prof. Brian Gazzard, Cyril Nemeth and Sandra Smith-Gordon and is chaired by Prof. Sir Christopher Edwards, Chairman of the Council of Governors and the Board of Directors.

4.0 Process

The person specification was agreed by the Board and it is attached in appendix 1 with a description of the role of a Non-Executive Director.

An extensive search was carried out by the employment specialist, Saxton Bampfylde Hever.

An advert for the post of a non-executive director was placed in the Sunday Times on 27 June 2010.

There were 16 candidates who responded to the national newspaper advertisement and 12 candidates were identified in the search process by Saxton Bampfylde Hever.

The Nominations Committee at its meeting on 16 July 2010 considered in total 28 candidates, out of which 13 candidates appeared to match the person specification closely with a further 15 candidates who met some of the elements required.

From that list of 13 candidates the Nominations Committee chose 11 candidates who matched the specification most closely based on CVs provided to Saxton Bampfylde Hever by each candidate (long-list). Six candidates were identified in the search process by Saxton Bampfylde Hever and 5 candidates were those who responded to the national newspaper advertisement.

The long-listed candidates were interviewed by Saxton Bampfylde Hever in August. Prior to the interviews all candidates received a detailed oral briefing from Saxton Bampfylde Hever, together with the description of the role of a Non-Executive Director and person specification contained in the ‘Information for Candidates’ document.

Results of those interviews were presented to the Nominations Committee short-listing meeting on 9 September 2010.

As a result of those interviews on 9 September the Nominations Committee short-listed 7 candidates for interview. The Nominations Committee noted that two long-listed candidates are not available for the panel interview on 15 September. It has been decided by the Nominations Committee that the Panel will interview 4 candidates on 15 September and another date will be set up to interview remaining 3 candidates.

Each candidate will be given the opportunity of one-to-one meetings with Heather Lawrence, Chief Executive of the Trust and Prof. Sir Christopher Edwards, Chairman to allow them to understand further the Trust's business.

The Nominations Committee Interview Panel consists of Prof. Brian Gazzard, Cyril Nemeth and Sandra Smith-Gordon, Prof. Sir Christopher Edwards and Jenny Hill, an independent assessor.

5.0 Decision/Action required

The Council of Governors is asked to note update on the progress.

The Nominations Committee will recommend a candidate for appointment by the Council of Governors for a Non-Executive Director of the Board of Directors of the Chelsea and Westminster Hospital NHS Foundation Trust after the interviews have been completed.

Vida Djelic
Interim Foundation Trust Secretary
9 September 2010

Appendix 1

The Role of a Non-Executive Director

Reports to: Chair of Board of Directors

Accountable to: Council of Governors

Committee membership: Assurance Committee (TBC) and Remuneration Committee

Key functions:

- To work with Executive Directors, in consultation with the Board of Governors, on the strategic and annual plans of the Trust, and to be involved in decisions that ensure that the priority health needs of the population served by the Trust are fully considered.

- To ensure that the Trust establishes key objectives to deliver the agreed plans and to review regularly performance against these objectives so that appropriate corrective action can be taken.

- To lead or participate in committees or sub-groups of the Board charged with specific activities to support the delivery of services.

- To oversee and seek assurance that effective financial control arrangements are developed across the Trust to secure high levels of probity and value for money.

- To oversee and seek assurance that processes and procedures are established to deliver high standards of professional, clinical, administrative and personal behaviours across the Trust.

- To represent the Trust in dealings with national, regional or local bodies or individuals to ensure that the views of a wide range of stakeholders are considered and the position of the Trust is enhanced.

- To support, and challenge where appropriate, the Chairman, Chief Executive and other Directors of the Trust to ensure that the workings of the Board of Directors conform to the highest standards of corporate governance and that the delivery of local health services is enhanced.

Person Specification

The successful candidate will bring a significant track record of achievement as an executive and very likely as a non-executive in a large and complex service industry most probably in a commercial environment. Experience of sound financial management and of the development of commercial opportunities will be important; additionally experience of large staff leadership will be a bonus. This individual will be a clear and strategic thinker with the confidence, credibility and sensitivity to engage with a wide range of audiences both inside and outside the Trust. The successful candidate could come from a variety of backgrounds.

Qualifications	**Strategic skills** Experience in a large service industry at a Board level Entrepreneurial experience Management experience **Knowledge** Areas of knowledge that would be useful to the Trust at this time include (but are not limited to): Business case analysis Environment Finance Human resources Information Technology Investment Law, especially Corporate Law Marketing Mergers & acquisitions Risk management Strategic Planning
Personal Qualities	Integrity Courage Good judgement Commitment to learning
Behavioural skills	Ability to present opinions clearly, frankly and constructively Willingness and ability to listen respectfully and make sure that they have understood what they have heard Ability to ask questions in a way that contributes positively to debates Flexible and open to new ideas and responsive to the possibility of change Dependability to do preparatory work and participate in meetings
Previous board experience	Experienced director Exposed to board practices: Executive or professional adviser to Board Service to charities (optional)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 16 September 2010

AGENDA ITEM NO.	2.7/Sep/10
PAPER	Re-appointment of Non-Executive Directors
AUTHOR	Vida Djelic, Interim Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper reports on the outcome of the appraisals conducted on non-executive directors seeking re-appointment following the expiry of their term of office on 30 October 2010.
DECISION/ ACTION	The Council is asked to note the reports and to approve the re-appointments as recommended.

Introduction

The Constitution of the Trust provides that 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 the procedures which the Board of Directors has approved. The process was first used in 2009 and was reapproved at the Board meeting on 29 July 2010. The appraisal process was presented to the Council of Governors on 21 July 2010.

In compliance with the Constitution and Monitor's Code of Governance which stipulates that the Board of Directors undertakes a formal and rigorous annual evaluation of its individual directors, the Chairman has conducted this evaluation.

NEDs were asked to complete the appraisal form. The Chairman asked for views from other Board members on each NED.

The Chairman met with individual NEDs to discuss their performance taking into account their views and those of other Board members.

Report on Non-Executive Director Appraisal

Name	**Charles Wilson**
Date of First Appointment	**11th September 2000**
End Date of Current Term	**30th October 2010**
Date of Appraisal	**September 2010**

Results of Evaluation – Charles Wilson

The result of this evaluation is that Charles Wilson continues to contribute effectively and to demonstrate commitment to the role which includes commitment of time for the Board, chairing the Assurance Committee meetings and other duties, in particular, the roles of Vice-Chairman of the Board and Senior Independent Director.

His length of service (ten years from date of first election) has been considered as part of the evaluation in the context of independence and the need for progressively refreshing the Board of Directors. The Council of Governors will be aware of the Code of Governance which states:

'**C.2.2** Non-executive directors, including the chairman, should be appointed by the Council of Governors for specified terms subject to re-appointment thereafter at intervals of no more than three years and to the 2006 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-appointment continues to be effective and to demonstrate commitment to the role. Any term beyond six years (e.g. two three-year terms) for a non-executive director should be subject to particularly rigorous review, and should take into account the need for progressive refreshing of the board. Non-executive directors may serve longer than six years (e.g. two three-year terms), subject to annual re-election. Serving more than six years could be relevant to the determination of a non-executive director's independence (as set out in provision A.3.1).'

The term of 9 years has been reduced to 6 years in the Code for 2010. As a result particular care was taken in the evaluation of Charles Wilson's role and the implication of a further year's term of office.

Charles Wilson is found to have remained independent and to possess the skills, knowledge, experience and unique personal qualities which are required for the particular roles of leading the Board and the Council of Governors should the Chairman be absent, unavailable or otherwise unable to discharge his duties and acting as an independent point of contact for the Board of Directors and the Council of Governors.

There have been no significant changes to his other commitments.

Recommendation

In accordance with section 2.3.1 of Standing Orders: 'For the Chairman and Non-Executive Directors, the term of office, in accordance with the terms and conditions of office, including remuneration and allowances, is decided by the Council of Governors in a General Meeting'.

The Council of Governors is asked to approve the re-appointment of Charles Wilson as non-executive director for a term of one year ending on 31 October 2011.

Report on Non-Executive Director Appraisal

Name	**Andrew Havery**
Date of First Appointment	**1st November 2003**
End Date of Current Term	**30th October 2010**
Date of Appraisal	**July 2010**

Results of Evaluation

The result of this evaluation is that Andrew Havery continues to contribute effectively and to demonstrate commitment to the role which includes commitment of time for the Board, including membership of the Finance & Investment Committee and Audit Committee.

His length of service (seven years from date of first election) has been considered as part of the evaluation in the context of independence and the need for progressively refreshing the Board of Directors. The Council of Governors will be aware of the Code of Governance which states:

'**C.2.2** Non-executive directors, including the chairman, should be appointed by the Council of Governors for specified terms subject to re-appointment thereafter at intervals of no more than three years and to the 2006 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-appointment continues to be effective and to demonstrate commitment to the role. Any term beyond six years (e.g. two three-year terms) for a non-executive director should be subject to particularly rigorous review, and should take into account the need for progressive refreshing of the board. Non-executive directors may serve longer than six years (e.g. two three-year terms), subject to annual re-election. Serving more than six years could be relevant to the determination of a non-executive director's independence (as set out in provision A.3.1).'

The term of 9 years has been reduced to 6 years in the Code for 2010. As a result practical care was taken in the evaluation of Andrew Havery's role and the implication of a further year's term of office.

Andrew Havery is found to have remained independent. He possesses particular expertise in the area of Finance and should continue to play a very important role as the Board faces the challenges of achieving its growth and development objectives against the background.

There have been no significant changes to his other commitments.

Recommendation

In accordance with section 2.3.1 of Standing Orders: 'For the Chairman and Non-Executive Directors, the term of office, in accordance with the terms and conditions of office, including remuneration and allowances, is decided by the Council of Governors in a General Meeting'.

The Council of Governors is asked to approve the re-appointment of Andrew Havery as non-executive director for a term of one year ending on 31 October 2011.

Report on Non-Executive Director Appraisal

Name	**Prof. Richard Kitney**
Date of First Appointment	**1st May 2006**
End Date of Current Term	**30th October 2010**
Date of Appraisal	**July 2010**

Results of Evaluation

The result of this evaluation is that Prof. Richard Kitney continues to contribute effectively and to demonstrate commitment to the role which includes commitment of time for the Board.

Prof. Richard Kitney is found to have remained independent.

The Chairman has asked Prof. Richard Kitney to take particular responsibility for Information Technology and academic development (especially with regards to the maintenance and development of our links with Imperial College).

Recommendation

In accordance with section 2.3.1 of Standing Orders: 'For the Chairman and Non-Executive Directors, the term of office, in accordance with the terms and conditions of office, including remuneration and allowances, is decided by the Council of Governors in a General Meeting'.

The Council of Governors is asked to approve the re-appointment of Prof. Richard Kitney as non-executive director for a term of two years ending on 31 October 2012.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 16 September 2010

AGENDA ITEM NO.	2.8/Sep/10
PAPER	Report on Chair Appraisal
AUTHOR	Vida Djelic, Interim Foundation Trust Secretary
LEAD	Charles Wilson, Vice Chairman and Senior Independent Director
EXECUTIVE SUMMARY	This paper reports on the outcome of the Chairman's appraisal.
DECISION/ ACTION	The Council is asked to note the results of the evaluation and to approve the re-appointment of Prof. Sir Christopher Edwards as the Chairman of the Board of Directors and Council of Governors.

Report on Chairman's Appraisal

Name	**Prof. Sir Christopher Edwards**
Date of First Appointment	**1st November 2007**
Date of Appraisal	**September 2010**

Introduction

In compliance with Monitor's Code of Governance which stipulates that the Board of Directors undertakes a formal and rigorous annual evaluation of its individual directors, the Senior Independent Director has conducted this evaluation in accordance with the process approved by the Board of Directors at its meeting in July 2010. This involves collaboration between the Senior Independent Director and the Deputy Chairman of the Council of Governors to seek the views of both directors and the governors in response to the Chairman's statement setting out his views of the extent to which he has fulfilled his stated responsibilities.

Governors were requested to convey their views to the Deputy Chairman of the Council of Governors on the Chairman's performance against the written statement provided by him. The Deputy Chairman of the Council of Governors shared this feedback with the Senior Independent Director. The SID then met with the Chairman to relate the views from the Board of Directors and the Council of Governors.

Results of Evaluation

The result of this evaluation is that the members of the Board, Non-Executive and Executive Directors, were agreed that the Chairman's statement truly reflected his performance and that of the Board throughout the year and unanimously praised him for the work and successful outcomes it outlined.

Individual comments from members of the Board indicated a high level of satisfaction with the Chairman's performance and praise for the contribution he has made.

Comments received from governors by the Deputy Chairman of the Council of Governors also indicated a high level of satisfaction and praise.

Recommendation

In accordance with section 2.3.1 of Standing Orders: ' For the Chairman and Non-Executive Directors, the term of office, in accordance with the terms and conditions of office, including remuneration and allowances, is decided by the Council of Governors in a General Meeting'.

The Council of Governors is asked note the results of the evaluation and to approve the re-appointment of Prof. Sir Christopher Edwards as the Chairman of the Board of Directors and Council of Governors for a term of three year ending on 31 October 2013.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 16 September 2010

AGENDA ITEM NO.	2.9/Sep/10
PAPER	Review of constitution
AUTHOR	Vida Djelic, Interim FT Secretary
LEAD	Cathy Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	This paper provides proposal for review of the Constitution.
DECISION/ ACTION	The Council of Governors is asked to note the paper and governors are invited to send their expression of interest in joining a group to Vida Djelic by 22nd October 2010.

1.0 Introduction

The Foundation Trust's constitution was approved by Monitor in 2006 as part of our application to become a Foundation Trust. There have been amendments which are described in the paper. This paper proposes a review of the whole constitution.

2.0 Background

It is Council of Governors' statutory responsibility as stipulated at section 7.3.1.6 of the constitution 'when appropriate to make recommendations for the revision of this constitution'.

Any amendments to the constitution require the approval of a majority of members present and voting at a members' meeting and then approval by Monitor. Monitor will check the amendment as well as ensuring changes were made in line with the constitution.

There is a Model Core Constitution issued by Monitor who require all new applicant Trusts to prepare their constitution on this basis. This however was not available at the time of our authorisation.

3.0 Changes to the constitution.

There have been two change requests to the constitution since we became a Foundation Trust in 2006. The changes included:

- changing to an opt-out scheme for staff membership
- removing the disqualification of volunteers from staff membership,
- clarifying what is to be taken into account in the non-executive director appointment policy
- listing the major nursing and education providers from which a Partnership Council Member may be appointed
- enabling non-employed staff members to join by application rather than by default
- enabling any person to be an independent assessor on the Nominations Committee, rather than the chairman of another Foundation Trust
- changing the name of Members' Council/Council Member to Council of Governors/Governors

3.0 Review of the Constitution

Advice will be sought from other Foundation Trusts who have undergone a review of their whole constitution as to the most effective process.

The views of the Board and governors will be important in agreeing any changes. In order to get governor input we will set up a 'task and finish' group. The terms of reference of this group are to be agreed and will depend on the process undertaken, but in any case will include identifying areas for change to the current constitution.

4.0 Decision/Action required

The Council of Governors are invited to send their expression of interest in joining a group to Vida Djelic by 22nd October 2010.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 16 September 2010

AGENDA ITEM NO.	2.10.1/Sep/10
PAPER	Patient Governors: their role, duties and constituents
AUTHOR	Edward Coolen, Patient Governor
LEAD	Professor Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper is a submission from a patient governor, Edward Coolen for discussion. The Council should note the relevance of this paper to two provisions of the Code: 'D.1.5 Governors should canvass the opinion of their members, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors.' D.1.6 The board of directors should consider and take account of the views of the Council of Governors on the NHS foundation trust's forward plan. Where appropriate, the board of directors should communicate to the Council of Governors where their views have been incorporated in the NHS foundation trust's plans, and, if not, the reasons for this.'
DECISION/ ACTION	The Council is asked to discuss the ideas proposed.

TO: The C&W Hospital NHS Foundation Trust Agenda Sub-Committee

AUTHOR: Capt. Edward Coolen (EC) Patient Governor
DATE: 11 June 2010

SUBJECT: PATIENT GOVERNORS : THEIR ROLE, DUTIES & CONSTITUENTS

1. Extracts from Page.4. *trustnews* April/May 2010

"Your Governors – Q&A

"What is their role?

1.1 "The Council of Governors represents the interests of Foundation Trust members and works with the Board of Directors as a **'critical friend'**, helping to shape the Trust's future.

1.2 "Governors have a **range of responsibilities** and in particular **two key roles**:

1. Advising the Board on forward plans of the Trust

2. **Communicating with** their **member constituencies** and **transmitting their views to the Board"**

1.3 **Notes**
The Author feels that:
It would be more appropriate to re-phrase paragraph 1.1 and
delete *'… as a critical friend'* and
insert,*'… as a constructively critical friend"*

And that the terms, ***communicating***; ***member constituencies (****and* ***constituents)***, should be clearly defined and promulgated.

2 Patients

Some C&W Patients **will be** Members of the Foundation Trust.
Other C&W Patients will **not** be members of the Foundation Trust.

3 Patient Governors

3.1 Notwithstanding the stated Governor key role identified at 1.2.2, **'Communicating with their member constituencies ….'**, and with particular reference to Patient Governors, there appears to be considerable confusion, within Governor ranks, regarding who, precisely, are the constituents of Patient Governors.

3.2 It has been put to the Author that a Patient Governor may only communicate with a member (who, presumably, happens to be a patient) and must not communicate with a patient who is not a member.

3.3 By any standards the view expressed at 3.2 appears patently absurd and in direct conflict with the statement at 1.2.2 that a Governor's responsibility is, **'Communicating with member constituencies and transmitting their views to the Board.'**

3.4 It is also in conflict with Monitor's Code of Governance as stated at,
"D.2.2 Led by the chairman, the Council of Governors should periodically assess their collective performance and regularly communicate to members details of how they discharge their responsibilities, including their impact and effectiveness …….. and communicating with their member constituencies and transmitting their views (*member constituencies' views)* to the Board of Directors."

3.5 Applying standard critical examination techniques how can the above be achieved if Patient Governors are not encouraged and allowed to regularly visit and communicate with their constituents? Realistically, it can only be done whilst patients are actually in hospital.

3.6 Despite repeated requests for facility to visit patients (be they members of the Foundation Trust or not) this matter has not been progressed.

3.7. The Author can think of no better way to improve patient morale than for in–patients to receive fairly regular visits from Patient Governors with whom they could discuss any problems, complaints or suggestions on a one-to-one basis. And if they have no problems such visits would give patients support, encouragement and company and the opportunity to comment on all the good experiences they have enjoyed at our hospital – in other words it would give the feedback essential to maintaining and improving our patient care and services which is Monitor's objective.

4. Summary

In rapid summary, Patient Governors are required by Monitor to regularly visit and communicate with their patient constituents and without such communication it is difficult to see how Governors can properly discharge or carry out their duties.
In addition, it is highly probable that patient morale would be hugely improved by regular Patient Governor visits and essential feedback gained.
Whether, or not, such visits are random or programmed is of little consequence.

4.1. The important thing is to get Patient Governors visits to Patients programmed in as quickly as possible.

EJC. 11/06/2010

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 16 September 2010

AGENDA ITEM NO.	2.10.2/Sep/10
PAPER	Governors' involvement in various sub-committees and activities
AUTHOR	Vida Djelic, Interim FT Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper provides an overview of governors involvement in various committees, sub-committees, groups and forums.
DECISION/ ACTION	Governors are encouraged to join the sub-committee and groups they find of interest.

Council of Governors

Category	Constituency	First Name	Last Name	Membership Sub-Comm. (1)	Agenda Sub-Comm. (1)	Quality Sub-Comm. (1)	Nominations Committee (1)	Assurance Committee (2)	Website Steering Gr. (2)
Public	Kensington and Chelsea 1	Eddie	Adams						
Staff	Allied Health Professionals, Scientific and Technical	Lucy	Ball						
Patient		Walter	Balmford		√				
Patient		Paul	Baverstock						
Patient		Chris	Birch	√					√
Public	Hammersmith and Fulham 2	Christine	Blewett					√	
Partnership	The Royal Marsden NHS Foundation Trust	Nicky	Browne						
Patient		Cass J.	Cass-Horne						
Patient		Alan	Cleary						
Patient		Edward	Coolen						
Public	Hammersmith and Fulham 1	Samantha	Culhane						
Staff	Management	Carol	Dale			√			
Chairman		Christopher	Edwards						
PCT	NHS Wandsworth	David	Finch						
Staff	Medical and Dental	Brian	Gazzard		√		√		
PCT	NHS Hammersmith and Fulham	Rosie	Glazebrook			√			
Public	Wandsworth 2	Del	Hosain	√					
Staff	Contracted	Jacinto	Jesus						
Public	Westminster 2	Martin	Lewis	√		√			
PCT	Westminster PCT	Catherine	Longworth						
Staff	Support, Administrative and Clerical	Charlotte	Mackenzie Crooks	√					
Partnership	Royal Brompton and Harefield NHS Trust	Duncan	Macrae						
Patient		Susan	Maxwell	√		√			√
Patient		Wendie	McWatters	√		√			
PCT	NHS Kensington and Chelsea	Edgar	Moyo						
Local authority	Westminster City Council	Cyril	Nemeth			√	√		
Staff	Nursing and Midwifery	Sue	Smith						
Public	Kensington and Chelsea 2	Sandra	Smith-Gordon	√	√		√		
Local authority	Royal Borough of Kensington and Chelsea	Frances	Taylor		√				
Partnership	Major Education Provider	Alison	While						
Patient		Taryn	Youngstein						

(1) Council of Governors Sub-Committees/Committees
(2) Trust Committees

Governors are represented on the following groups:

- Patient Environment Action Team (PEAT)
- HIV forum
- Families, Children's and Young persons forum

In addition, there are also the following patient groups:

- Heart Support Group
- Intensive Care Unit Ex-Patient Support Group
- Maternity Services Liaison Committee
- Learning Disability Support Group
- Rheumatoid Arthritis Patient Support Group

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 16 September 2010

AGENDA ITEM NO.	2.11/Sep/10
PAPER	FTGA/FTN Development Day 23 July 2010 – feedback
AUTHOR	Carol Dale, Staff Governor
LEAD	Carol Dale, Staff Governor
EXECUTIVE SUMMARY	This paper provides feedback from the FTGA/FTN Development Day held on 23 July 2010
DECISION/ ACTION	The Council is asked to note the paper and to consider the feedback and presentation and make suggestion for items to be discussed at the next meeting to Vida Djelic.

FTGA / FTN Joint Development Programme for FT Governors - 23 July 2010

The following governors attended from Chelsea & Westminster Hospital NHS Foundation Trust: Carol Dale, Sian Nelson and Sue Smith.

The Conference had four speakers and gave an update on The NHS – where it is and where it is going, what are FT's achieving?, the role of the governor, and an introduction to finance.

The session 'Governors Making a Difference' gave those attending a space to share best practice and the following ideas were discussed.

The Council of Governors and Trust Board might want to consider some of these ideas as a way of engaging with the trust to fulfill their role.

Best Practice ideas:

1. Being involved in the preparation for Care Quality Commission Inspections
2. Developing a programme of quality assurance ward / departmental visits
3. Being part of reconfiguration teams, both operational and strategic such as quality circles, employee engagement and workforce planning
4. Governors to be involved in the appointment of Non-Executive Directors and other senior posts (with training given beforehand)
5. Representing the Trust at local events to recruit new members, especially in hard to reach groups (County Show as an example, alongside clinical stands or stall to attract visitors)
6. Being involved with groups external to the Trust but linked, third sector and community groups, PCT groups
7. Undertaking a review of Foundation Trust function, efficiency and practices
8. Being involved in inducting new members to the council and acting as a 'buddy'
9. Arranging and participating in Governors seminars between full council meetings, with guest speakers and preparation
10. Developing a governors 'skills audit' to inform the election process and to use each governor to their best ability
11. Arranging pre-election seminars to ensure aspiring governors understand the role and are informed
12. Getting involved with local schools and colleges to increase membership, with links to work placements and volunteering
13. Governors being allocated to certain departments, or in our case Directorates
14. Governors involvement and participation in equality and diversity events and groups
15. Governors involvement in carers groups and service user groups
16. Being involved in Business planning and strategic development days with the board

Action: The Council of Governors is asked to consider the feedback and presentation and make suggestion for items to be discussed at the next meeting to Vida Djelic.

FTGA

Foundation Trust
Governors' Association

Debate | Exchange | Learn

Foundation Trust Network

Welcome to the Governors' Development Programme

Foundation Trust Network
NHS CONFEDERATION

The NHS: immediate and future challenges

Mark Redhead, Head of Policy, FTN

Foundation Trust Network
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NHS Reforms since 2003

Providers:

- NHS Foundation Trusts – 20 authorised in 2004; there are now 130 – the majority of NHS providers.

Commissioners:

- Consolidation of PCTs (2006) and development of world class commissioning (2007);

System:

- Re-organisation and new roles for SHAs (2006)
- Regulatory arrangements - Monitor (2004), CQC (2009) etc.

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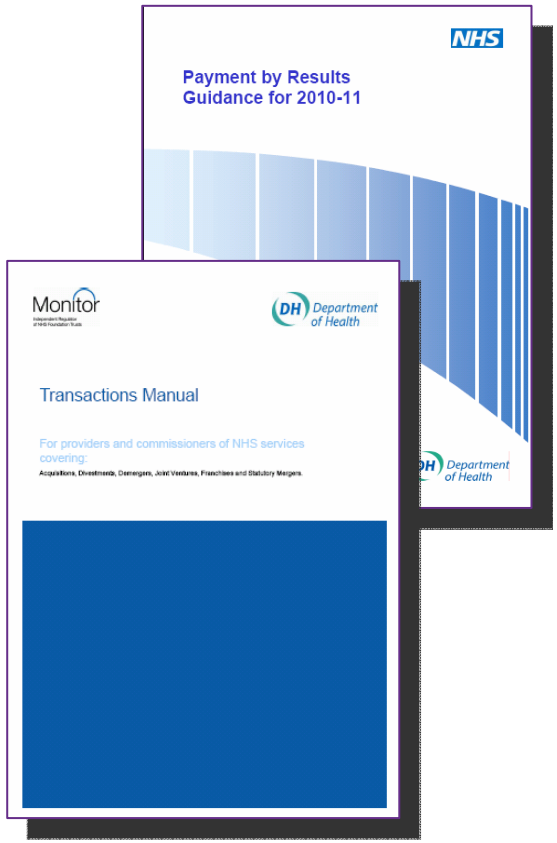
Some tools of the system architecture

- Payment by results / tariff
- Standard Contracts
- Co-operation and Competition Rules and Panel
- Transactions Manual



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Monitor
Independent Regulator
of NHS Foundation Trusts

- Assesses applicants for FT status
- Monitors FT activities to ensure that they comply with the requirements of their terms of authorisation through the Compliance Framework
- Focus on risk-based regulation - of finances and quality of governance
- Powers to intervene in the running of a foundation trust in the event of failings
- De-authorisation

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CareQuality Commission

- Assuring safety and quality, performance assessment of commissioners and providers, monitoring the operation of the Mental Health Act and ensuring that regulation and inspection activity across health and adult social care is co-ordinated and managed.

- Registration on entry standards and enforcement powers

- Assessments of quality - periodic reviews, special reviews

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Quality in the present economic climate

- The Next Stage Review 2008 launched quality as the organising principle of the NHS – a shift from an earlier focus on volume and access.
- Current focus is implementing better quality while responding to the current economic pressures faced by the service (QIPP)

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QIPP – Quality, Innovation, Productivity, Prevention

- Used as a catch-all initiative to address the vast economic challenges facing the NHS, including the taking out £15 – 20bn over the next 3 years.
- Focussed on efficiency and quality, using service reconfiguration to deliver on productivity.
- Being taken forward nationally through 12 national work streams, as well as SHA QIPP plans.
- Was begun by the last government but has been retained by the Coalition as a programme of work

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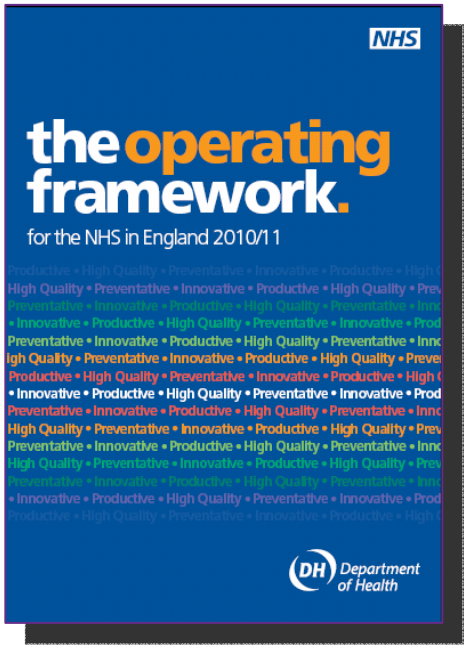
The Operating Framework 2010-11

Further lever to deliver on the QIPP challenge:

- Flat cash…but NHS has high in-built inflation
  - Agenda for Change
  - Product and cost inflation
- Activity cap set at outturn 2008/09
- Marginal pricing 30% over these levels
- Money in SHAs
- Transfer of risk onto providers
- Sustainability concern



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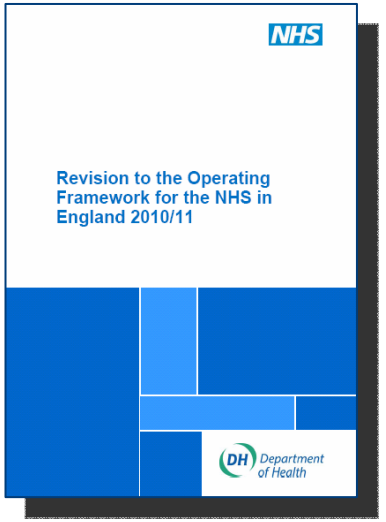
The revised Operating Framework (21 June)

- Retains efficiency challenge of £15-20bn by 2013-4 with £10bn by 2012-3;
- Amended the 4 hour A&E target to 95%;
- Removal of performance managed 18 weeks target;
- Cancer and C.diff targets remain;
- 0% (maximum) tariff uplift for 2010-11 and the next three years following remains in place;
- Still a 30% marginal rate for emergency admissions ...and re-admissions within a 30 day period will not be paid (this is being queried with the DH).



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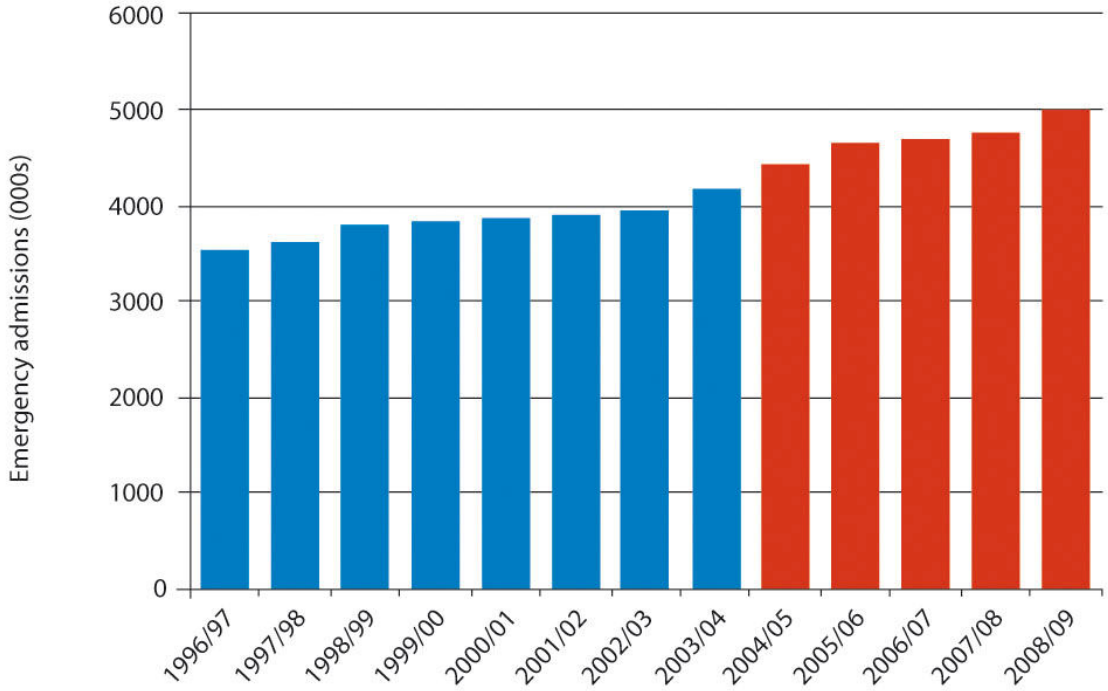
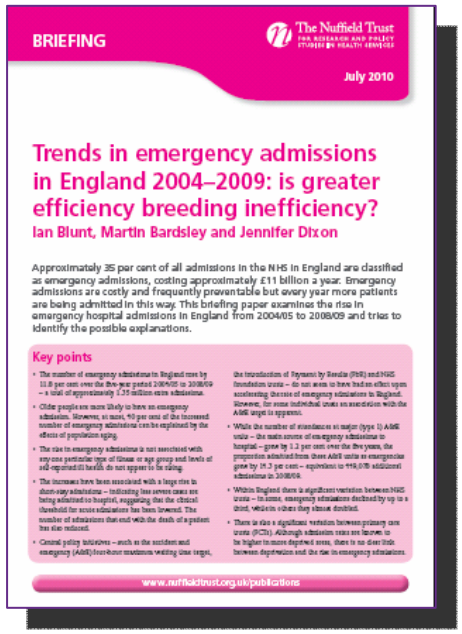
Nuffield Trust report on increasing emergency admissions




BRIEFING

The Nuffield Trust

July 2010

Trends in emergency admissions in England 2004–2009: is greater efficiency breeding inefficiency?

Ian Blunt, Martin Bardsley and Jennifer Dixon

Approximately 35 per cent of all admissions in the NHS in England are classified as emergency admissions, costing approximately £11 billion a year. Emergency admissions are costly and frequently preventable but every year more patients are being admitted in this way. This briefing paper examines the rise in emergency hospital admissions in England from 2004/05 to 2008/09 and tries to identify the possible explanations.

Key points

www.nuffieldtrust.org.uk/publications

Emergency admissions increased 11.8% between 2004 -9, with a large increase in short stay admissions.

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30 day responsibility for readmissions

FTN and Dr Foster analysis shows that FTs could lose 1.7% of income / £1.5bn when this is implemented….

But this could equally be an opportunity for FTs to assume responsibility for rehabilitation services across a care pathway that we understand will come with money attached.

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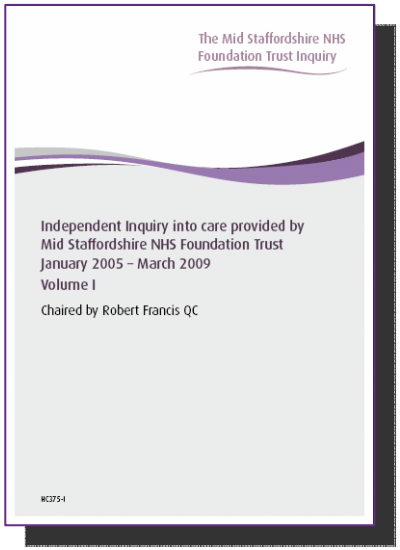
Delivering openness and accountability

- Political focus on accountability, especially following Mid-Staffs / the Francis Inquiry
- Lead governor arrangements
- Relationship with Local Involvement Networks
- Relationship with members
- Quality Accounts – developed with full stakeholder engagement



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The Coalition agreement (20 May)

- Funding for the NHS will increase in real terms in each year of the parliament; service re-design will be clinically led.

- The deficit reduction programme takes precedence over any of the other measures in the agreement, and the speed of implementation of any measures that have a cost to the public finances will depend on decisions to be made in the Comprehensive Spending Review (20 October 2010)

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The Emergency Budget (22 June)

- Pay freeze in public sector for 2011-12 and 2012-13; increments still in place and some uplift for the lowest paid.
- Health spending protected but other departments have cuts.
- IFS have said that 25% cuts across public sector would only be 14% if health budget was unprotected.

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The White Paper
12 July 2010

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White Paper - commissioning framework

- NHS Commissioning Board from April 2012 – allocates and accounts for resources; and commissions where a GP consortia approach is inappropriate

- GP commissioning consortia (500+) take on bulk of commissioning; and local authorities take on health improvement. Development of a market in commissioning?

- PCTs and SHAs abolished by 2013

- NHS Outcomes Framework from 2011-12 to set strategic direction and hold Board and consortia to account.

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White Paper – NHS foundation trusts

- FTs set free from constraints they are under, in line with their original conception, so that they can innovate….but no privatisation.
- Removal of PPIC;
- De-authorisation provisions to be repealed
- Easier to merge
- Tailored governance arrangements to local needs (e.g. employee-led social enterprises for community services with no endowed assets?)
- All FT public provider sector within three years – drop dead date of 2014
- Employers to lead on workforce and pay issues

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White Paper – regulation framework

- Providers will have a joint licence overseen by both Monitor and CQC

- Monitor will promote competition, regulate price and support continuity of services (where not the responsibility of the Board).
  - levers available to ensure essential services are maintained: e.g. powers to protect assets; impose a risk pool levy and authorise special funding arrangements for unviable essential services.

- CQC will be strengthened as a quality inspectorate and will license against quality and safety requirements. BUT quality improvement done through contracting.

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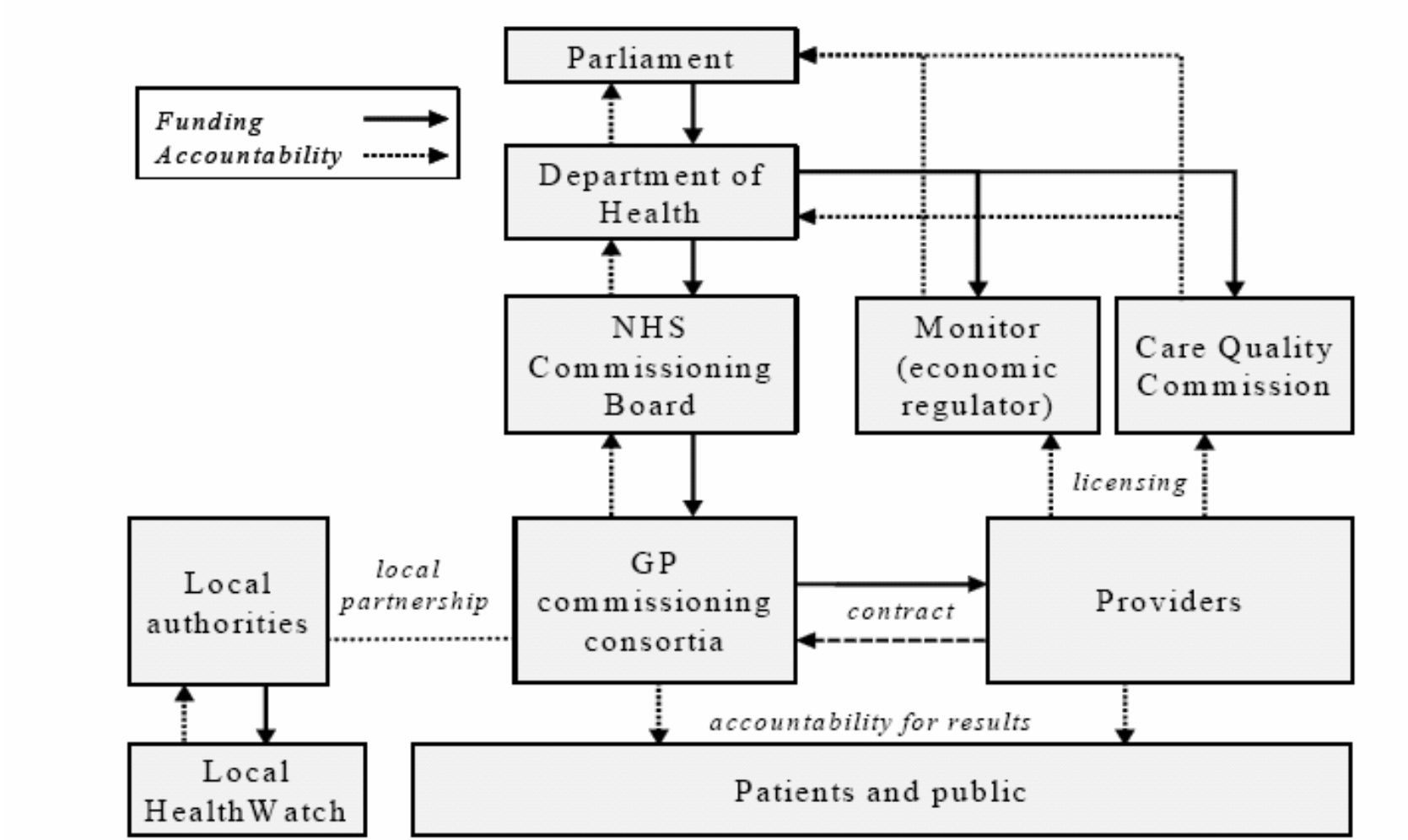
The new system



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Future of NHS foundation trust assets

- Andrew Lansley, in announcing the White Paper said:

  "I am looking to a world where the Department of Health doesn't own foundation trusts"

- The main advantage of taking FTs off the balance sheet is to promote FT freedoms as their capital investment will no longer count against department limits.

- This approach has been endorsed by Steve Bundred, Chair of Monitor.

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FTN priorities: Situating NHS foundation trusts

- FTs as quality brand public health providers
- Close to Co-operatives and mutuals
- Governance is key - Strategic boards with developed local accountability through members and governors the guarantee of independence
- If other ‘independent public’ models develop would we let them into membership?
- If economics drives ‘whole place public investment’ would we grow the affiliation beyond health?

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Enhanced roles and responsibilities for NHS foundation trusts in the new health industry

- Workforce planning and development
- Quality and Safety
- Governance and Leadership
- Working in partnership with other providers and stakeholders

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Welcome to the Governors' Development Programme

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Governance and Accountability

- John Coutts Governance Advisor FTN

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Governance in Foundation Trusts

- The Challenge for the next 3-5 years
  - Unprecedented reductions in public spending
  - Insufficient new resources in the NHs to cope with inflation and rising demand
  - The rest of the system that operates around foundation trusts is going to disappear
  - The accountability landscape is volatile
  - Increased public expectations
  - The lessons of the Mid Staffordshire Enquiries

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The Challenge for the Future

General Observations

- There is no simple means by which organisations can immunise themselves against failure
- Good corporate governance is crucial, but alone is not enough
- Clarity of purpose is essential
- Strong and coherent leadership from the board is crucial

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Corporate Governance

The Role of the Board

- Boards collectively and directors individually, need a clear understanding of the board's role:
  - To set strategic direction
  - To supervise the executive and drive performance
  - Taking decisions reserved to the board
  - Facilitate the board being held to account
- Board meetings are where the board the 1st three of the above are carried out, but not where they are held to account – in the private or public sector

The Board

- The Director's Role
- Board members are individually and collectively responsible and accountable for ALL of the board's work
- All board members are responsible for providing appropriate challenge not just NEDs
- Directors collectively and individually have a responsibility for ensuring they have the right level of information in the right form, the right support and for reviewing this frequently.

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The Right Balance

- Board Composition
- The Chair/Chief Executive relationship needs to function well - a role for the SID?
- The board needs to be fit for purpose, individually and as a team – what does this mean for NEDs?
- Executives need to act as directors, not as managers
- The composition of the board needs to be subject to regular review – the right balance now may not be the right balance going forward.

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Leadership & Processes

•Clear Leadership, the Right Processes

- Leadership from the board setting a clear vision and strategic leadership based on the core business of the trust: to provide safe, high quality services to the public
- Processes and procedures are there to support good governance, they are not in themselves sufficient to deliver good governance

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Building in Accountability

•Compliance and Assurance

- Boards must satisfy themselves that the performance standards they have set are the right standards
- Boards need to assure themselves that compliance on paper means compliance in the real world and that quality really is being delivered
- Boards can benefit by working effectively with governors to test out compliance and assurance

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The FT Governor

•A Critical Partner

- Governors form part of a critical partnership with the board of directors:
  - Carrying out statutory duties
  - Representing the interests of members
  - Influencing strategic direction
- Governors will want to reflect the high expectations of members and the community when holding the board of directors to account for the performance of the trust.
- Getting the right balance needs support, skill, commitment, time and trust.

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Accountability in Action

–Each group appoints the next:

- Members elect Governors
- Governors appoint the Chair and NEDs
- The Chair and NEDs appoint the Executive Directors

–Each answers to the next:

- Executive Directors run the services and answer to the board
- NEDs represent the board and answer to Governors
- Governors are elected by and answer to the membership
- Members are representative of the public and the public purse

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The Governor Role

- The Key Elements
  - Carrying out Statutory Duties
  - Representing the interests of members
  - Influencing Strategic Direction
  - Judging performance

- Each of these is of growing importance as the effects of the financial crisis hit public services.

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Representing Members

•Representing members or representative of members?

- Elected governors need to be representative of their electorate
- Involved in developing strategies for filling gaps in membership
- In touch with the membership: open days, constituency meetings, newsletter articles etc.

Influencing Strategic Direction

–How?

- Governor meetings
- Joint strategy meetings with the directors
- Constituency meetings
- Public presentations

–What?

- What people want from their health service
- What is viable and can be delivered
- Public consultation and involvement
- But allow the directors the freedom to lead the operational management of the plans

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Judging performance

- At the right level
- Not duplicating the work of NEDs, but adding value by:
  - Looking at the overall performance of the trust
  - Checking that quality data conforms with the user/staff provider experience
  - Looking at the overall financial position
  - Looking at how the board gets assurance on performance

Constructive Challenge

•But it is OK for governors to ask Boards the hard questions, for example:

- Can we afford our current strategic plans?
- What other options should we consider now?
- Can we afford to provide all the services we currently offer while maintaining quality or should we be looking to specialise?
- What level of support can we expect and what are we willing to provide to help the trust?

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Governors and the BoD

•Governors can help to establish and agree the principles

- Honesty
- Openness & Confidentiality
- Transparency

•Agree ground rules

- Communication, access to & sufficiency of information
- Points of contact
- Resolving disagreements

What works

•Each of these work well for some trusts, they may or may not suit yours:

- Council of Governors receiving the same reports as the Board
- Joint strategy days with Board
- Governors jointly responsible for production of Governance handbook
- Governors attending Board as observers
- Governor skills training: recruitment, managing performance

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Some Pitfalls

•What to Avoid

- Governor bodies and boards of directors regarding the the other as the opposition
- Trying to replicate the work of NEDs
- Being a single issue campaigner

What to ask for

- The right level of access to NEDs and Executives
- The right level of information in intelligible form

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The Director's dilemma

- The traditional dilemma
  - How do you exercise enough control to manage risk while allowing scope for innovation in strategy?
- The new dilemma for boards
- How do you:
  - Provide dynamic leadership,
  - Maintain quality,
  - Win the support of stakeholders,
  - Keep the support of staff
- All at a time of unprecedented reductions in funding for public services?

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Some Conclusions

•A Work in Progress

- There is no blueprint and no easy answers
- Good will and good communication are key
- Good relationships are essential and need to be based on a common understanding of roles and responsibilities.
- The Board of Directors is responsible for making accountability relationships work, but Governors have a role in making them work well
- Openness, transparency and accountability are central in identifying problems early and dealing with them effectively.

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But there isn't much time

- Questions?

- john.coutts@nhsconfed.org

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NHS Finances

•The National Context

Paul Betts, Economic Adviser, FTN

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Economic Context

By 2011/12 £20 billion gap in health finances in best case scenario

Wanless prediction- gap could be £39 billion in worst case

NHS ‘protected’ from the additional £6bn spending reduction but.. IFS have said that 25% cuts across public sector would only be 14% if health budget was unprotected.

Pay freeze but inflationary pressure in Agenda for Change - up to £640m

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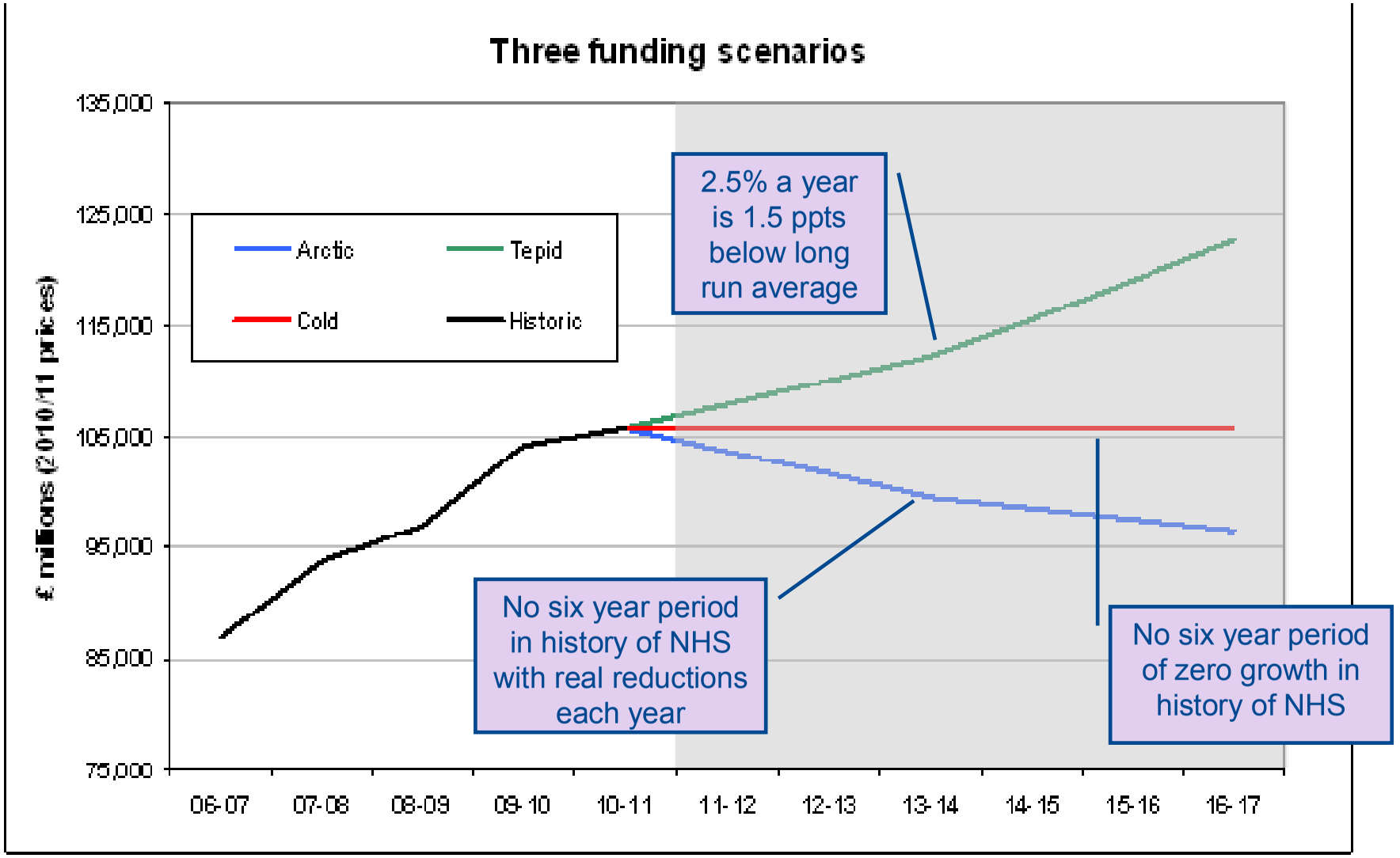

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Efficiency Challenge

- Productivity increases required 4-4.5% year on year
- Over past 10 years 0.4% (at best!)

New Government: “We will cut the cost of NHS administration by a third and transfer resources to support doctors and nurses on the front line”

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Stakeholder and Public Expectations

- Growing public demand on health resources
- Expectation/Demography/Life-style
- High expectations on efficiency
- Increased expectations on quality
- Next Stage Review
- Quality Accounts
- Growing demands for corporate citizenship
- Leaders in local communities
- Concern for environment

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Key Challenge

•Realise savings without negative impact on quality and whilst meeting stakeholder expectations

•(+ renewed focus from the new Government on GP led/approved change)

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Further Information

•General Economic situation and the impact on public services

- Filling the hole: how do the three main UK parties plan to repair the public finances? http://www.ifs.org.uk/publications/4848
- Protecting NHS spending from 2011 likely to require large cuts to other department budgets or tax rises
http://www.ifs.org.uk/publications/4568

•NHS financial situation

- Dealing with the downturn: the greatest ever leadership challenge for the NHS?
•http://www.nhsconfed.org/Publications/leadership/Pages/Dealing-with-the-downturn.aspx
- How cold will it be? Prospects for NHS funding: 2011- 2017
•http://www.ifs.org.uk/publications/4567

23 June

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How Do NHS Finances Reach Your Trust

•Paul Betts, Economic Adviser, FTN

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Responsibilities of the Governors

- Considering the Foundation Trust's annual report and its annual plan
- Appointing, removing and deciding the terms of office of the chair and other non-executive directors
- Approving the appointment of the chief executive
- Agreeing with the audit committee the criteria for appointing, reappointing and removing external auditors
- Informing Monitor if the FT is at risk of breaching its terms of authorisation if these concerns cannot be resolved at local level
- Including 'operate effectively, efficiently and economically and as a going concern'

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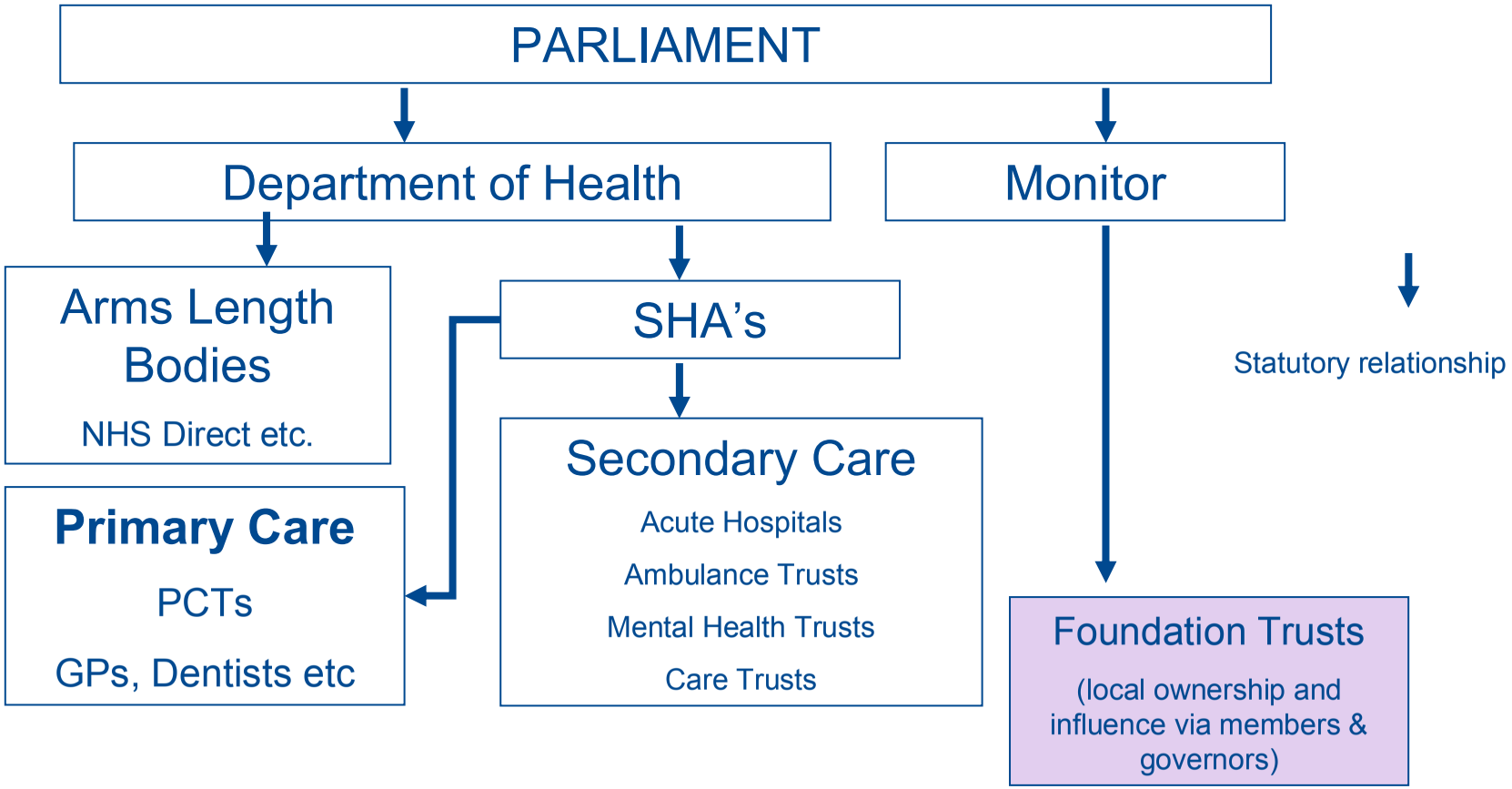
FTs remain part of the NHS, run as public benefit corporations.

The old way...



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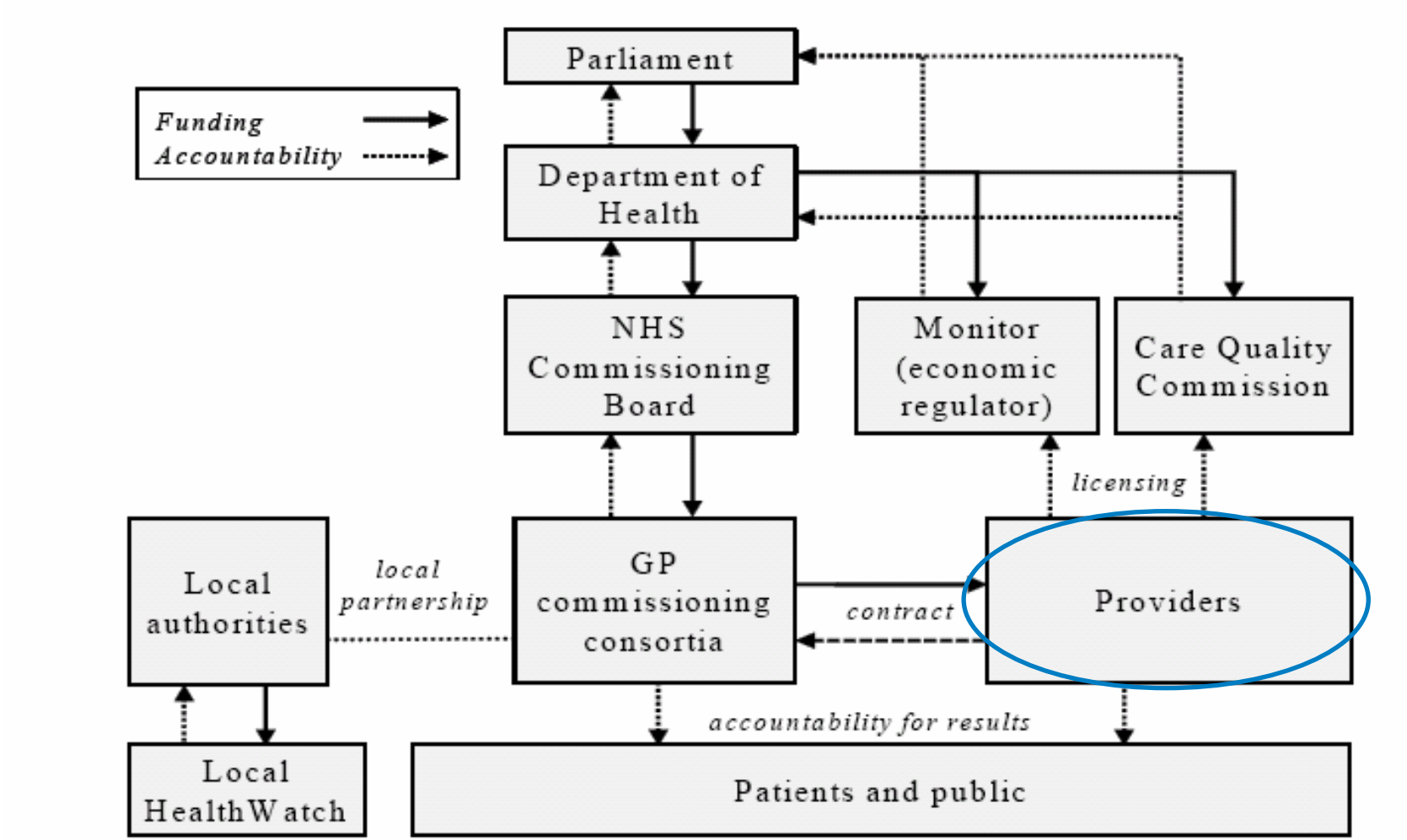
The new way – FTs the only stable part!



Source: NHS White Paper

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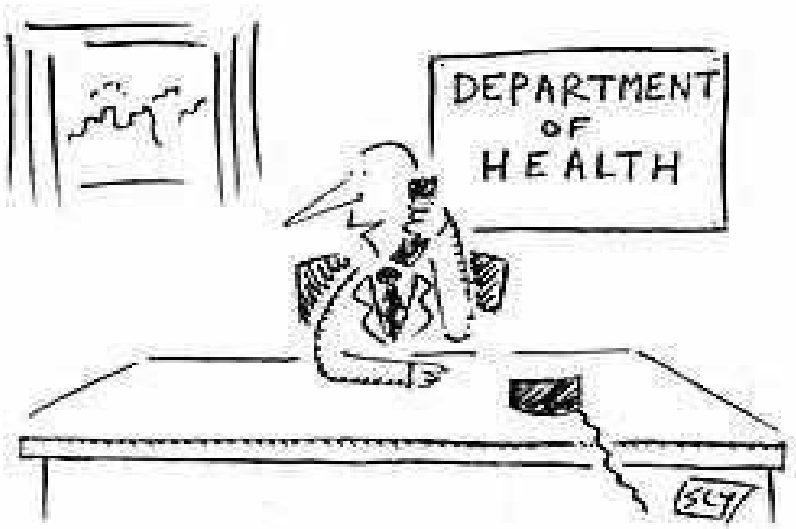
FTs are free from direct control by Department of Health and this will continue..



"Your hospital needs more nurses? So hire more nurses!"

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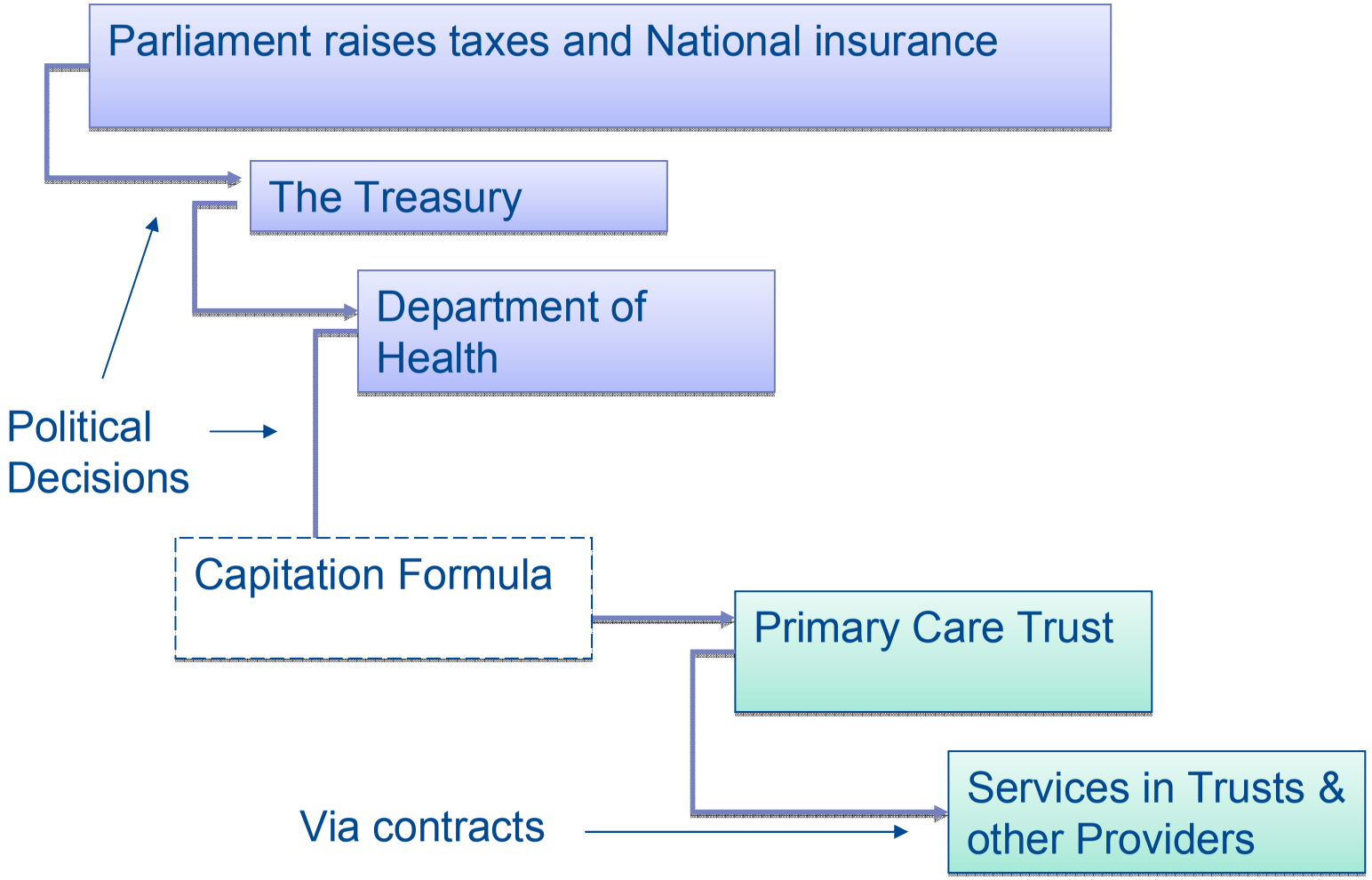
The old way - fixed funding flows from Parliament to PCTs and then to providers



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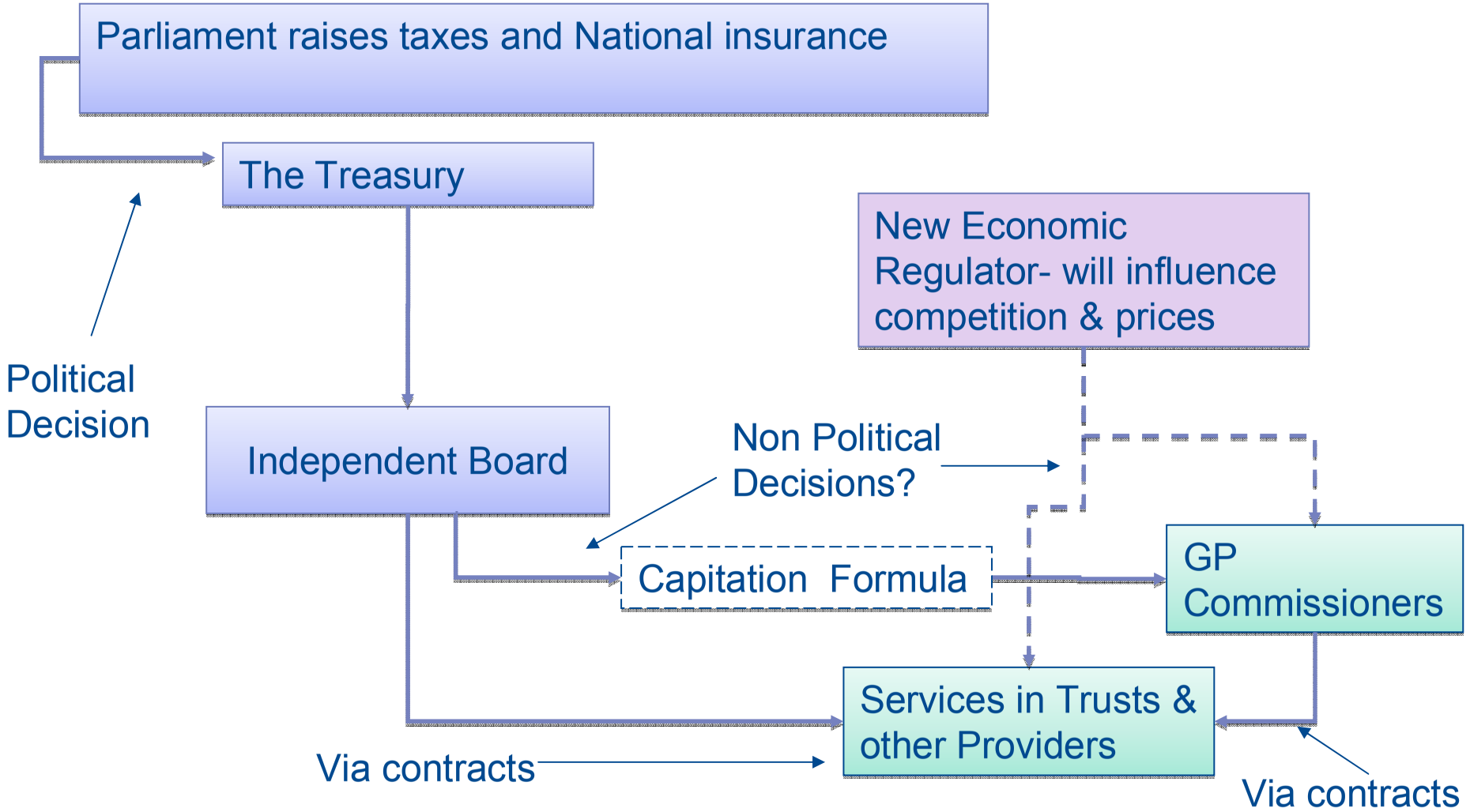
The new way – potentially not that different...



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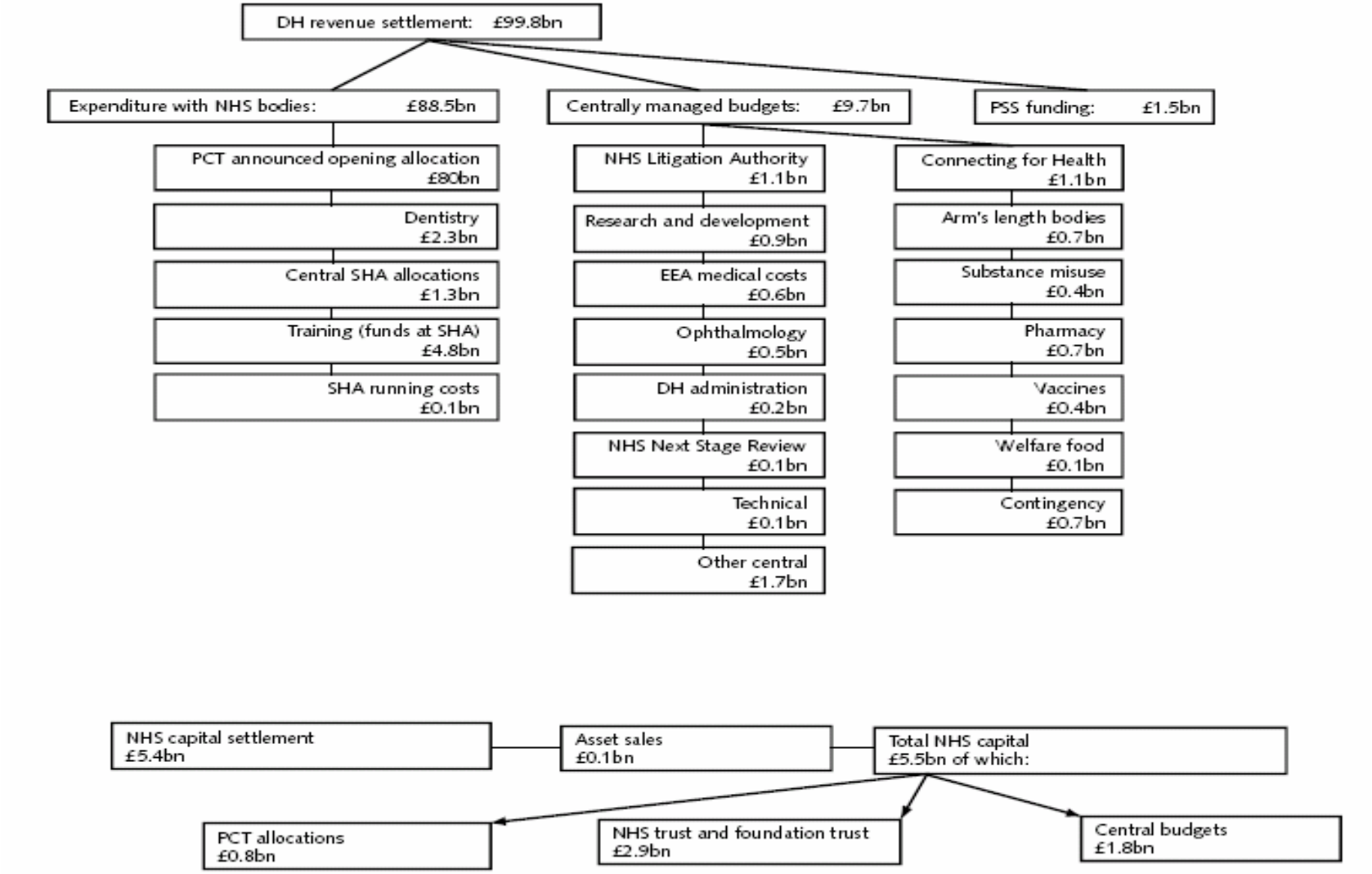
From Taxes to Service



Source: Department of Health Annual Report 2009

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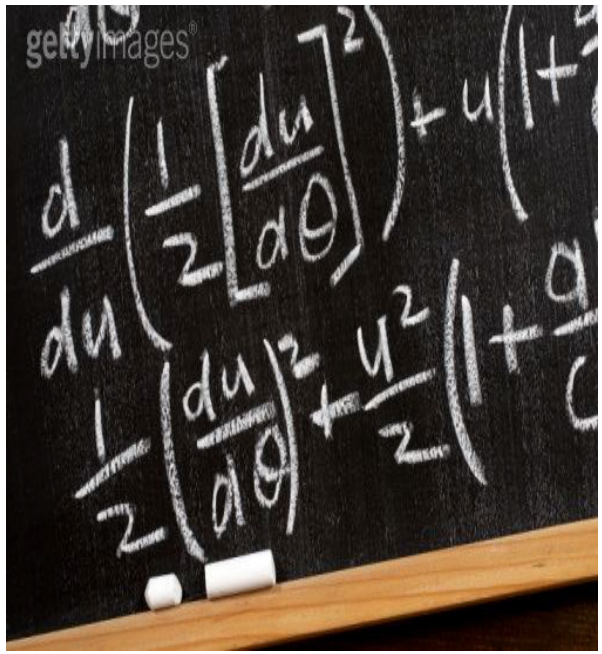
Commissioner Allocations

- Allocated on the basis of:
  - historic level of funding
  - minimum distribution of additional resources
  - assessment of how the PCT stands against its fair share of resources



- Weighted capitation formulae – age, deprivation, unavoidable costs – will this now change?

- Distance from target and pace of change

- New announcement of ring fenced public health budgets with a health premium to most disadvantaged areas.

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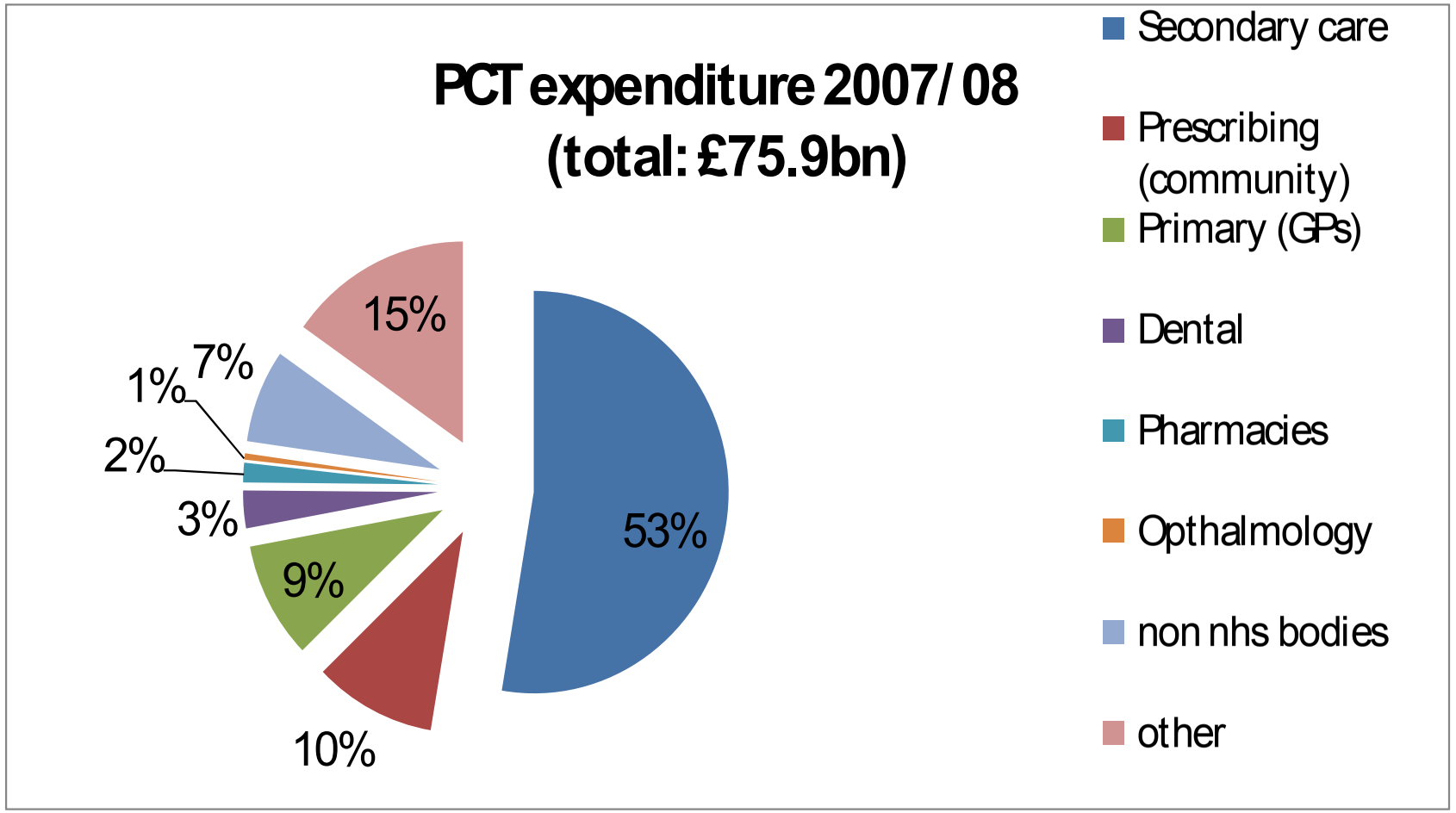
How funds are spent



Source: Department of Health Annual Report 2009

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Triggers for transfer of Funding to FT

•Contracts/Service Level Agreements (SLAs)

– Legally binding
– Standardised – Local concordat
– Financial penalties for failures in quality eg MRSA rates
– Incentives for success i.e. Discharge summaries
– Specified levels of activity
– Quality funding – 10/11 1.5% of contract value

•Main types

–Cost per case (most common in acute hospitals):

- Paid for each treatment undertaken under payment by results – a list of tariff prices by Healthcare Resource Group HRG e.g. For each hip replacement the trust receives circa £5K

–Block:

- Fixed amount paid for a service for a year eg. Doctors training

–Cost and Volume:

- Like a block but activity over or below certain levels triggers increases or reductions to the annual amount e.g ambulance journeys

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How are prices fixed?

- Procedures categorised into Healthcare Resource Groups (HRG)

- Tariffs developed on a prices = cost basis

- Costs calculated from an annual data collection known as “reference costs”

- Price based on average cost adjusted for inflation, efficiency, changes in technology and system incentives – “Payment by Results” system

- System may be reformed to “best practice” tariffs and maximum prices

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Productivity and Efficiency

- Set as part of Tariff calculation
- 3% for 2009/10 and 3.5% in 2010/11
- Impact of national financial position
- Impact on NHS financial position
- Adjustments to rules to incentivise certain behaviours e.g. 30% marginal tariff on emergency admissions
- Provider income increasingly linked to patient experiences

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Investment Funding

- Fixed Assets & Equipment

- Foundation Trusts:
  - Power to borrow up to limits included in Terms of Authorisation (refreshed each year with Risk Rating)
  - Use Existing Resources eg re-invest cash generated
    - Current Operational Surpluses
    - Sale of Assets
  - Enter into other arrangements/partnerships to develop facilities/services
    - Subject to restrictions around Private Patient Income Cap

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Future of NHS foundation trust assets

- Andrew Lansley, in announcing the White Paper said:
  "I am looking to a world where the Department of Health doesn't own foundation trusts"

- The main advantage of taking FTs off the balance sheet is to promote FT freedoms as their capital investment will no longer count against department limits.

- This approach has been endorsed by Steve Bundred, Chair of Monitor.

- What does this mean in practice?

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Capital

- What will be the new arrangements for access to capital?
- There will not be a lot of public capital available

The Daily N

Thursday, June 17, 2010

New Hospital Cancelled

A string of North East Labour MPs attacked Mr Alexander in the Commons over the decision to cancel the planned Â£450m "super hospital" on Teesside, accusing the Tories and Lib Dems of tearing up their manifesto commitment to protect front line health spending.

- The problem with private capital is the higher cost

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Monitor Performance Regime

- Risk rating of 1 to 5
  - to both the plan at the beginning of the year and financial performance in year (usually each quarter)

- 1 indicates high risk of significant breach of authorisation

- 5 indicates low risk of significant breach of authorisation

- Ask questions if below 3

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Consequence of Risk Ratings

Diagram 5: Financial risk rating

	Description	Implications
Rating 5	• Achieving weighted average of 5 across assessed components and no over-riding rules applied	• Quarterly/six monthly monitoring* • MDCR is 40%
Rating 4	• Achieving weighted average of 4 across assessed components and no over-riding rules applied	• Quarterly monitoring • MDCR is 25%
Rating 3	• Regulatory concerns in one or more components. Significant breach is unlikely	• Quarterly monitoring, however monthly monitoring in case of deteriorating trend or recovering from a 2 rating • Supplementary information if required • MDCR is 15%
Rating 2	• Risk of significant breach in the medium term, e.g. 12 to 18 months in the absence of remedial action	• Monthly monitoring with supplementary information and service line information • Remedial plan may be required • Potential for intervention under section 52 of the Act • MDCR is 10%
Rating 1	• High probability of significant breach of Authorisation in the short term, e.g. < 12 months, unless remedial action is taken	• Likely intervention under section 52 of the Act • MDCR decided case-by-case

* At Monitor's discretion, after four consecutive quarters rated 5, green, green, as described in section 2.2

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How Does Monitor Assess Financial Performance?

Diagram 3: Indicators used to derive the financial risk rating

Financial criteria	Weight, (%)	Metric to be scored	Rating categories 5	4	3	2	1
Achievement of plan	10	• EBITDA* achieved (% of plan)	100	85	70	50	<50
Underlying performance	25	• EBITDA* margin (%)	11	9	5	1	<1
Financial efficiency	40	20 • Return on assets excluding dividend (%)	6	5	3	-2	<-2
		20 • I&E surplus margin net of dividend (%)	3	2	1	-2	<-2
Liquidity	25	• Liquidity ratio** (days)	35	25	15	10	<10

Financial risk rating is weighted average of financial criteria scores

* EBITDA: Earnings before interest, taxes, depreciation and amortisation. EBITDA (and other financial metrics) may be adjusted by Monitor for any 'one off' non recurring revenue or costs

** The liquidity ratio is defined as cash plus trade debtors (including accrued income) plus unused working capital facility (up to a maximum of 30 days) minus (trade creditors plus other creditors plus accruals) expressed as the number of days operating expenses (excluding depreciation) that could be covered

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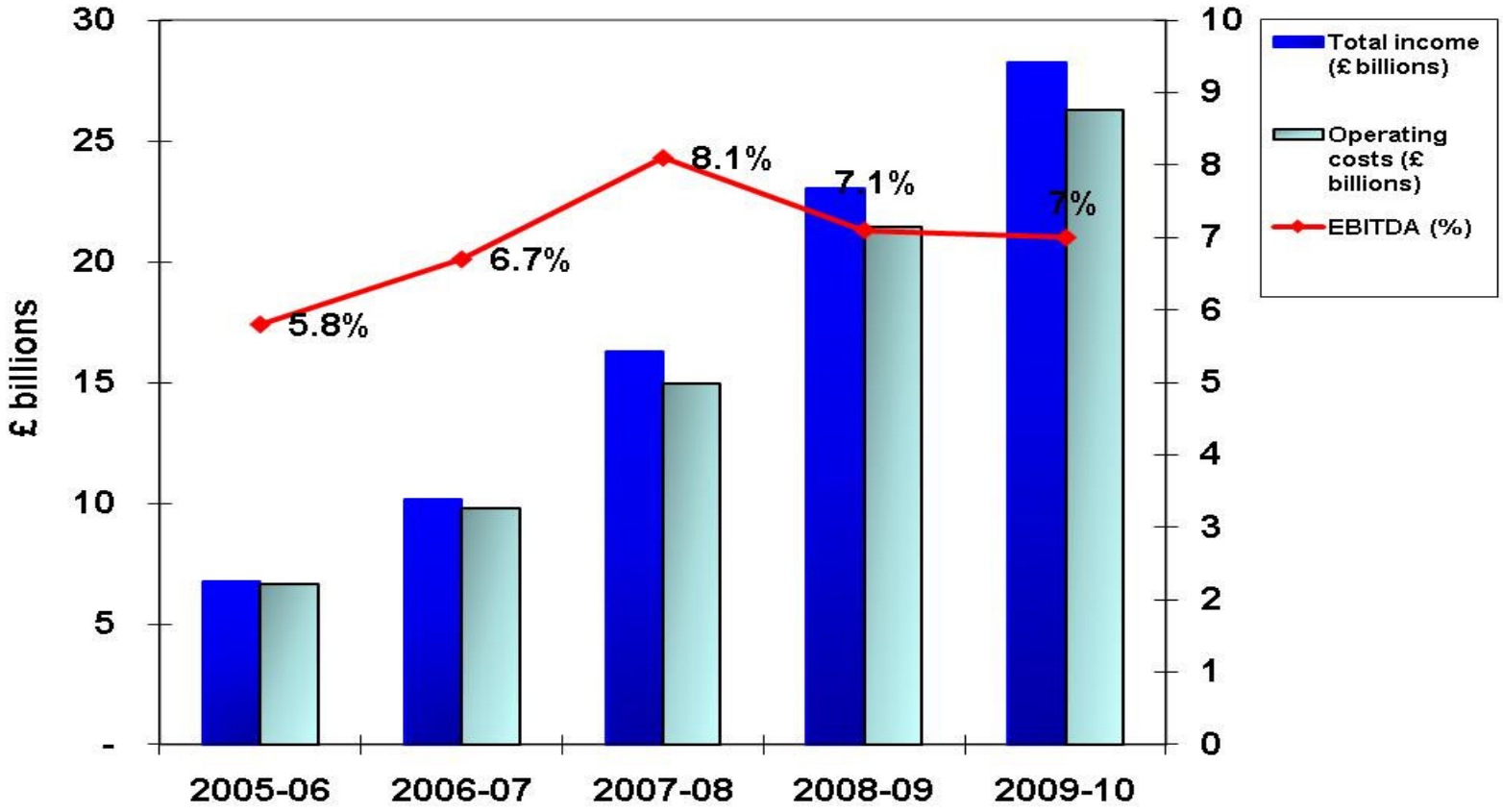
NHSFTs profitability has declined following earlier years of increase



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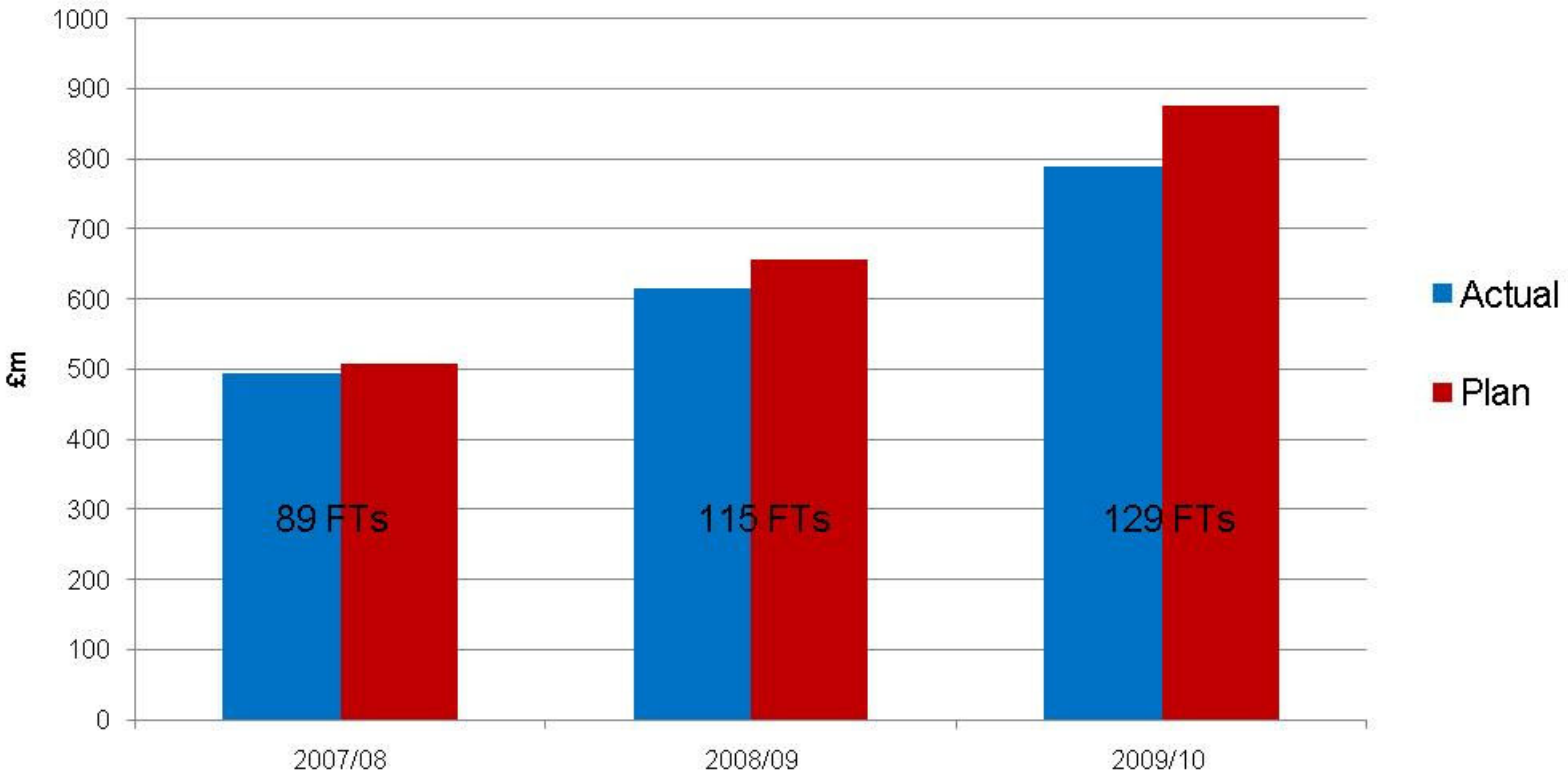
Cost Improvement Plans – historic performance



Variance (to plan): -£14m -£41m -£88m

A significant proportion (27%) of CIPs delivered in 2009/10 were from income generation schemes; this type of CIP will be increasingly difficult to generate in the future given expected spending constraints.

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Annual Report

- Summarises activities and performance for the previous year – financial and non financial

- Presented to a meeting of the Board of Governors convened within a reasonable timescale after the end of the year

- But only after accounts are laid before Parliament

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Monitor
Independent Regulator of NHS Foundation Trusts

Monitor's view of the financial environment and challenges facing FTs (7 July)

- Effective planning needed beyond the immediate year
- Robust assurance on data needs to be in place
- Cost improvement plans are going to be challenging
- Work with commissioners on their plans
- Review strategic portfolio of service lines – profitability / exit?
- Transactions an option – forwards into primary care or horizontal?
- Managing internal and external stakeholders – role for governors?

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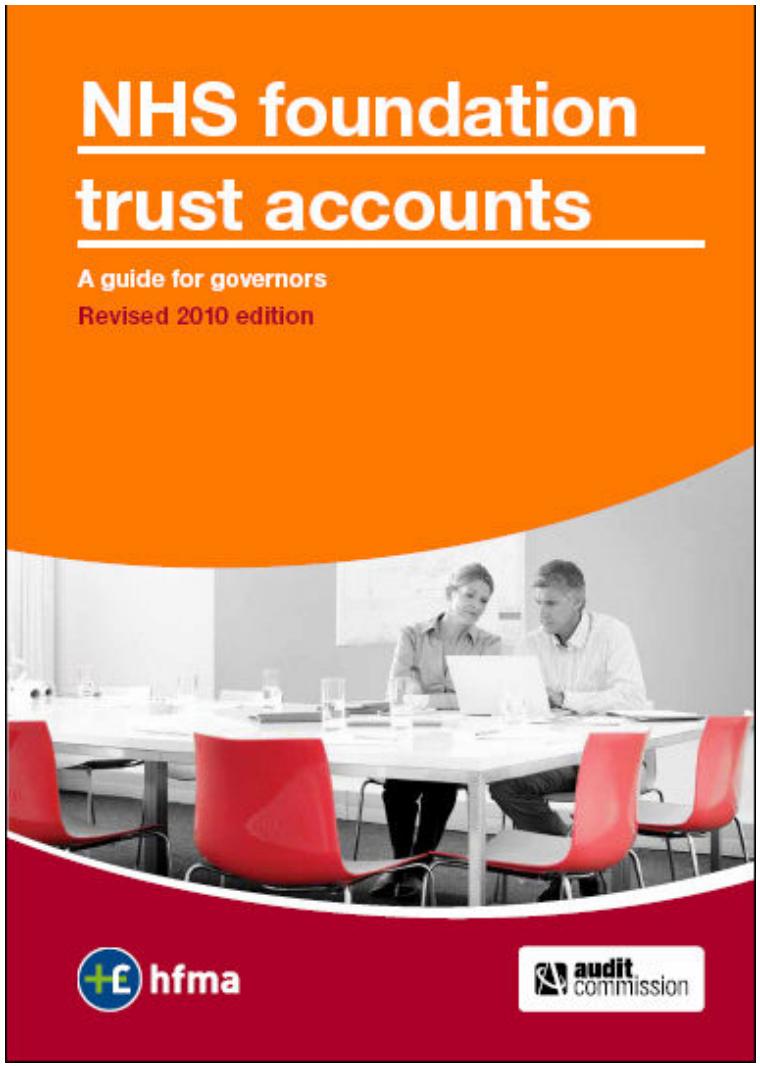
How to get more information on the Annual Report

- Useful guide to understanding and interpreting your annual report available from the Audit Commission:

- http://www.audit-commission.gov.uk/health/audit/financialmgmt/nhsaccountsguidesfornonexecutives/pages/foundationtrustsaguideforgovernors.aspx



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Responsibilities of the Governors

- Considering the Foundation Trust's annual report and its annual plan
- Appointing, removing and deciding the terms of office of the chair and other non-executive directors
- Approving the appointment of the chief executive
- Agreeing with the audit committee the criteria for appointing, reappointing and removing external auditors
- Informing Monitor if the FT is at risk of breaching its terms of authorisation if these concerns cannot be resolved at local level
- Including 'operate effectively, efficiently and economically and as a going concern'

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Issues for the Future

- National Financial Position
- New Budget and Comprehensive spending review
- Impact on NHS position (protected?)
- Darzi Review and Quality Drivers
- Service Redesign – GP and locally led?
- GPs with hard budgets commissioning hospital services
- New role for Monitor as Economic Regulator

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Further Information

- Your Finance Director and his/her team
- www.dh.gov.uk
- www.hfma.org.uk
- www.nhsconfed.org/
- www.monitor-nhsft.gov.uk
- http://www.audit-commission.gov.uk/health/audit/financialmgmt/nhsaccountsguidesfornonexecutives/pages/foundationtrustsaguidefforgovernors.aspx

FTGA

Foundation Trust
Governors' Association

Debate | Exchange | Learn

Foundation Trust Network

Welcome to the Governors' Development Programme

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 16 September 2010

AGENDA ITEM NO.	2.12/Sep/10
PAPER	Council of Governors Funding Report
AUTHOR	Part A: Vida Djelic, Interim FT Secretary Part B: Matt Akid, Head of Communications Part C: Sian Nelson, Membership and Engagement Manager
LEAD	Cathy Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	Part A: The report provides an overview of the use of the Council of Governors budget to Month 4 of FY 10/11. Part B: This is an application for £4,000 from the Council of Governors budget to fund a communications campaign to publicise the Trust's 4 priorities for quality improvement to key audiences including staff and patients. Part C: This is an application for an awning for the Mobile Health Clinic to ensure Governor's engagement activities are conducted in a comfortable and weather proof area.
DECISION/ ACTION	Part A: The Council of Governors is asked to note the report. Part B: The Council of Governors is asked to approve funding to enable the launch of the Quality communications campaign in October. Part C: The Council of Governors is asked to support a request for funding of the Mobile Health Clinic awning.

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.

The recurring budget was adjusted in the following financial year (2010/11) for the effect of inflation which is estimated at £500 bringing the total budget available in 2010/11 to £100,500.

2.0 Update

At the last meeting of the Council of Governors it was agreed that £2,158.48 will be provided for funding improvements to the Information Zone. The Council of Governors also agreed to funding of £2k per year for the quality award for 2010/11and the additional £400 for the staff survey.

3.0 Funding Overview

Of the £100,500 circa £56k has been accrued for the activities listed in the table below which were approved by the Council of Governors. It leaves circa £54k in the budget to be spent for the remainder of the 2010/11 FY.

4.0 Use of funds FY 10/11

TABLE 1

Activity 10/11	Estimate
Trust Open Day 2010	£15,000
Recruitment of new members via Campaign for pre-election	£2,000
Recruitment campaign for the Annual Members' Meeting	£2,000
Directory of Services	£19,817
Discharge Leaflets	£8,200
Learning Disability Membership Leaflet	£1,304
Membership recruitment via Mobile Health Clinic	£3, 539.10
Improvements to the Information Zone	£2,158.48
Quality Award including the staff survey	£2, 400
TOTAL:	**£56, 418.58**

Part B

QUALITY CAMPAIGN – COMMUNICATIONS PLAN

1. Aim

To communicate the Trust's 4 priorities for quality improvement to key audiences including staff and patients.

2. Background

Following consultation with key stakeholders, the Trust Board of Directors agreed 4 priorities for quality improvement in 2010/11:

- Reduce hospital acquired preventable venous thromboembolism by 20%
- Achieve a progressive improvement in issues identified in the Inpatient Survey relating to communication, information and responsiveness to the personal needs of patients – supported by a specific objective to improve the patient experience in Maternity and Paediatrics
- Meet agreed targets based on National Confidential Enquiry into Patient Outcome & Death (NCEPOD) recommendations for emergency surgery
- Reduce falls resulting in moderate or major harm by at least 25%

These priorities are included in the Trust's Quality Account – published on the Trust website and on the NHS Choices website – and they also form part of the Trust's Annual Review 2009/10 which was published in the August/September edition of *Trust News* and sent to all Foundation Trust members.

The Head of Communications presented a proposal for a communications campaign to promote the Trust's priorities for quality improvement at the Council of Governors Quality Sub-Committee meeting on 3 September – the Sub-Committee supported the campaign and agreed that a bid for £4,000 funding for communications materials should be submitted for approval to the Council of Governors

3. Campaign name/branding

Branding the campaign will give it an identity and make it recognisable to target audiences – it will also enable us to link a number of different initiatives or priorities under a single heading.

The Quality Sub-Committee agreed on 3 September that the campaign should be branded *Quality Matters: Priorities for quality improvement 2010/11*.

4. Tactics

Strong clinical leadership of the campaign is required. The Medical Director will be the figurehead of the overall campaign and there will be 'clinical champions' for each of the 4 priorities, responsible for working with the Communications Department on a campaign and ensuring that the campaign is an integral part of any meetings or forums relating to the priority.

5. Key audiences

- Staff
- Patients and the public including Foundation Trust members
- Patient groups – eg Kensington & Chelsea LINk

- Partner organisations – eg Royal Borough of Kensington & Chelsea Overview and Scrutiny Committee on Health, local PCTs, voluntary organisations etc
- GPs/other primary care professionals

6. Proposed communications activity

It is proposed that implementation of the campaign should start in early October and be sustained until the end of March – this is therefore a 6-month campaign strategy.

6.1 Internal communications (Trust staff)

- **Team Briefing** - face-to-face briefing and electronic version emailed to all staff for face-to-face briefing by line managers
- **Trust News** - monthly staff magazine
- **'Pocket size' staff information cards** - 'reminders' of key information
- **Posters**
- **PC desktop icon**
- **Intranet**
- **Daily Noticeboard email bulletin**

6.2 External communications (patients, public, Foundation Trust members, patient groups, partner organisations, GPs etc)

- **Trust website**
- **GP newsletter**
- **'Pop-up' display stands** - 6ft high x 2ft wide displays to be used in public areas of the hospital to raise awareness

7. Resources

Some of the proposed communications activity outlined above will require funding – notably staff information cards and 'pop-up' display stands – and the Quality Sub-Committee on 3 September agreed that funding this campaign would be an appropriate use of Council of Governors resources. The Sub-Committee proposed that £4,000 would be an appropriate budget.

For decision

- The Governors are asked to approve this request for funding.

Matt Akid
Head of Communications

Part C

Mobile Health Clinic Awning

1. Introduction

1.1 Chelsea and Westminster Hospital NHS Foundation Trust launched a mobile health clinic in February 2010 with the purpose of addressing health in the local community and targeting hard to reach, diverse groups. The aim is for Foundation Trust Membership to increase alongside clinical projects.

Using the mobile clinic is an opportunity for the Trust to place itself at the heart of its community, to reach diverse, often vulnerable groups, and demonstrate commitment to the constituencies that we serve.

1.2 The mobile health clinic held its first project at Chelsea Football Club in February 2010. The service offered health screening to football fans and the local community. The project received media applause and strong support from users of the service. Volunteers attended the event to recruit members but struggled outside due to cold, raining weather conditions.

1.3 Users of the service were invited to give their feedback on the Patient Experience Tracker (PET). The results were positive and 98% of users said they would recommend the clinic to others. This is encouraging for future events.

1.5 A Mobile Health Clinic Steering Committee has been set up and members include personnel from finance, operational management, medical, nursing and outreach, the Director of Operations and the Membership and Engagement Manager. The steering group have invited a Governor member to represent the Council of Governors.

2. Aims for the Council of Governors

2.1 To foster communication and representation of the Council of Governors on the Mobile Health Steering Committee, and enable the Governors to attend community events to reach and engage with diverse groups in the community, increasing membership recruitment.

2.2 For the Council of Governors to provide strategic and financial support to the Mobile Health Steering Committee.

2.2 Aims of the Mobile Health Clinic and membership engagement:

- Promote health and wellbeing through booked events
- Market the Trust to Foundation Trust members and local residents
- Develop excellent communication between the Council of Governors representatives and Foundation Trust members
- Address issues of public concern
- Foster partnership working
- Reach and engage with diverse groups in the community
- Recruit to membership

2.2.1 Discussions have been held with Governors who are members of the Membership Sub-Committee. Governors wish to utilise the mobile health clinic to reach and engage members in their constituencies.

Members of the Membership Sub-Committee will attend and promote membership on the mobile health clinic at the forthcoming Notting Hill Carnival where the bus will be situated at London Lighthouse. Further projects are in development e.g. clinical delivery at Queen Park Rangers Football Club. However, these events will be funded by the Sexual Health Services at Chelsea and Westminster Hospital and therefore does not require funding from the Council of Governors.

Suggestions from the Membership Sub-Committee have been made for:

1. A young persons and families Teddy Bears Picnic and Teddy Bear Hospital to celebrate and promote the paediatric services development and re-build.
2. The mobile clinic to attend Sainsbury's car park, Pimlico in the Westminster constituency. To host a 'wellness' clinic.
3. Attendance at local markets, for example, Hammersmith Shepherds Bush, Lyric Square Farmers Market, Wandsworth's Hildreth Street market, Battersea High Street market or Northcote Road Street market, North End Road market in Fulham and/or to North Kensington's Portobello Road street market.

However, organising these events solely through the Council of Governors budget would be too costly. A proposal has been made at the Mobile Health Steering Committee to invite Governor Representation on the committee and encourage Governors to attend Trust booked events.

The mobile clinic is compact. It contains two consultation rooms and a small reception area to sit four people, including the receptionist. It is not possible to accommodate Governors in the reception area.

Adding an external awning to the vehicle will provide an additional area for Governors to sit outside in a weather proof area, and accommodate table and chairs. Membership application forms can be placed on the desk. Engagement with members will be more private and dignified than on the street, especially in cold wet weather.

3. Implementation

3.1 The awning can be fitted before the Autumn Season to ensure Governors conduct their engagement activities in a weather proof area. It is made to measure, has a solid base and covered sides.

4. Funding

4.1 Funding is requested from the Council of Governors for a total of £5,875.

5. Actions for the Council of Governors

The Council of Governors is invited to comment on the proposal and to support the Membership Sub-Committee request for funding of the Mobile Health Clinic awning.

Sian Nelson
Membership and Engagement Manager

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 16 September 2010

AGENDA ITEM NO.	2.13/Sep/10
PAPER	Minutes of the Council of Governors Quality Sub-Committee meetings held on 3 September 2010 (draft)
AUTHOR	Vida Djelic, Interim Foundation Trust Secretary
LEAD	Catherine Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	The key points are: The committee commented on the terms of reference of the Whole Systems Delivery Group. These were subsequently discussed at the Quality Committee. The updated terms of reference of the Whole Systems Delivery Group and the Discharge Task Force Group will be circulated to the Council of Governors requesting volunteers to notify Scott Bennett if they are interested in joining either group. The committee were advised of the progress with the Leaving Hospital Booklet, which has been funded by the Council of Governors. The Quality sub-committee governors will comment on it. A proposal for communicating quality priorities was discussed and it was agreed that a proposal would be put to the Council of Governors for funding. This is included in the funding paper. The brand 'Quality Matters' was agreed and a further paper will be presented to the executive to launch the campaign. The committee agreed to comment on answers to the FTGA document about patient safety and this will be made available to the governors at the Council of Governors meeting in September.
ACTION	To note.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Quality Sub-Committee meeting, 3 September 2010

Draft Minutes

Attendees	Carol Dale	CD	Staff Governor – Management
	Susan Maxwell	SM	Patient Governor
	Wendie McWatters	WMW	Patient Governor
	Sandra Smith-Gordon	SS-G	Public Governor – Kensington & Chelsea 2
	Mike Anderson	MA	Medical Director, Chairman
	Therese Davis	TD	Interim Director of Nursing
	Catherine Mooney	CM	Director of Governance and corporate Affairs
	Jane Tippett	JT	
			Assistant Director of Nursing
	Vida Djelic	VD	Interim Foundation Trust Secretary
	Scott Bennett (in part)	SB	General Manager of Operations
	Paul Morrison (in part)	PM	Nurse Lead

1	**Welcome and Apologies**	**MA**
	Apologies were received from Rosie Glazebrook and Martin Lewis.	
2	**Minutes of previous meeting 9 July 2010**	**MA**
	The minutes were approved as a true and accurate record of the previous meeting.	
3	**Matters arising**	**MA**
	MA said that the feedback from Helen Elkington, Head of Facilities, was that gowns were discussed at the PEAT meeting. New gowns had been purchased but the feedback from patients was not positive and we have ordered new gowns. MA asked for the costs of the new gowns. **Helen Elkington to provide costs of new gowns.** TD said she walks around the hospital twice a week with Marie Courtney, Facilities Manager, to look at cleanliness. She has asked Facilities for a list of the worst floors and will review these and look at the capital allocation. SS-G said she walks round with the Friends trolley and she thinks the worst floors are where beds make holes. MA invited SS-G to pass her observations to TD. CM said that the matter arising re whether GS was a member might not be relevant and this was addressed in MAk's paper later.	**HE**
	SS-G to pass observations on hospital floors to TD.	**SS-G**
	Leaving Hospital	

	a) Terms of Reference Whole System Planning and Delivery Group SB, General Manager of Operations introduced the Whole System Planning and Discharge Group terms of reference. He said the purpose of the group is to develop a relationship across boundaries to smooth the transition when patients leave the hospital. It is broader that just discharge e.g. it will look at winter planning. The focus is on quality e.g. delays and how the experience can be more patient focused. The Whole System Discharge Group (WSDG) is a more strategic group than the old discharge group and has representatives from the four boroughs and PCT, public and patient representatives. The terms of reference are draft and will go to the Quality Committee for ratification. In addition a Discharge Task Force Group has been set up which is focused on medicine and surgery patients but will probably expand to other directorates. The task group is focusing on STEP discharge (safe, timely, effective and personal). It will ask what measures of good discharge are. SB felt that governors could contribute SM said that Jim Smith felt that he was discharged too early and that social services should have been aware. He was back in hospital again in a week's time as there was nobody to take care of him. SB responded that this is the type of issue that the group will consider and there are mechanisms in place to refer patients to social services. Some of these measures are about the quality of discharge. He said readmissions are not necessarily a good indicator of poor discharge as patients may be re-admitted for another reason. SS-G said that in her view discharge takes so long and no-one tells patients what is going on MA said that the governors need to be asked if they want to be involved in the WSPD group which is more strategic or the Discharge Task Force Group which is more focused around medicine and surgery or both. In response to MA's question about the frequency of meetings SB said that the WSDG meets monthly and the Discharge Task force meets weekly. SS-G suggested that all governors should be invited to join either group. CM suggested that the terms of reference of the WSDG should reflect the performance report previously considered by the Discharge Group. JT made a comment about the long title of the group. In response to CM's question about the measures of quality SB said that the group has measures but we will also ask patients as to what they consider would be right measures. CM suggested we get a group of interested governors to meet as 'one-off' in order to find out what is important to them.	

	SB to consider this proposal. WMW said she was impressed with help she received from the hospital staff while in the hospital. **MA confirmed that all governors should be invited to be members.** **The Quality Sub-committee governors to make any further comments on the Terms of Reference of the WSDG by Monday 6th September.** **b) Leaving hospital booklet** SB introduced Paul Morris, a nurse lead who is project managing the redevelopment and rewrite of the leaving hospital booklet (previously called the discharge booklet). He reminded the committee that the governors have funded the development of this booklet. PM said he has collated some information for the updated version and said that once a working draft is ready he will ask the sub-committee for comments. It is likely that the first working draft will be ready by the end of September. MA said we should aim to send it out for comments at the beginning of October. TD said that at the Membership Sub-Committee meeting held yesterday there was a representative from StartHere Charity who proposed a pilot of the Patient Information System. She suggested that if we decide to proceed it can be linked to the leaving hospital booklet.	**SB** **SB** **All**
	Draft booklet to be circulated to the Quality Sub-Committee for comments	**PM**
4	**Communications plan for quality objectives**	**MAk**
	MAk reminded the sub-committee that the Board approved the Trust's four priorities for quality improvement in 2010/11. These are outlined in the Quality Account but this is quite a large document with a lot of information and the priorities need more publicising.	
	MAk said that some work has already been done e.g. VTE awareness led by Helen Yarranton, and Jane Tippett and Sian Nelson have communicated regularly on patient experience. At the last Quality Sub-Committee meeting in July there were a number of ideas and he had been asked to develop this further and present a proposal. He asked the group for comments on a 'brand name'. After some discussion the group agreed on 'quality matters' as there are several interpretations which can be used to advantage. SS-G said that although she knows they are not arbitrary, the priorities seem so. Patients think quality is how they are treated i.e. the patient experience. Safety and effectiveness does not make so much sense to them. CM felt that would be the case if an operation had gone well and	

	there had been no infection, but might not be the case if a procedure had been unsuccessful or they had developed MRSA. She emphasised that the campaign was directed more at staff than patients, as if staff do not know what our priorities are they cannot help deliver them. She noted that the reason for the selection of the priorities was described in the Quality Account but perhaps should be part of the campaign. TD outlined her ideas for developing a Patient Experience Strategy which will focus on what matters most to patients. She plans that we will come up with three campaigns under the 'patient experience' section. She said that she thought the internal staff survey (the governors' staff survey using 'survey monkey') would be invaluable in checking out what staff thought the main issues were. She saw this as an opportunity for this to become part of the Quality Account for the next year. WMW said she thought this would be of value to patients and thought that what worried patients was acquiring an infection whilst in the hospital. CM emphasised that there is a need to communicate the current quality objectives and we are aware that staff do not know them. CM said that we need to work constantly with all staff on promoting them. MA said there are so many different objectives and staff are sometimes unclear what these relate to (e.g. corporate objectives, Trust's quality targets, national quality targets, departmental targets, etc). There needs to be an explanation about the reason for having each objective CM suggested we make the wording of objectives more meaningful to staff so that they are easy to understand and remember. She thought a campaign should also include management responsibilities e.g. are the objectives discussed and communicated at meetings? MAk said that a strong clinical leadership is necessary and that clinicians need to take ownership of and communicate priorities for quality improvement. CM said TD referred to engagement in order to identify future priorities and she felt this needed to run in parallel. SS-G suggested we produce a small card with the Trust's four priority objectives. The sub-committee felt it was a good idea. TD suggested that they can also appear on staff computers as a screen saver. MAk suggested we start a wider engagement and organise an event to inform patients and public about what we do. TD saw this as a good opportunity to be linked to the Seasonal Working Conference. MAk also suggested we can have a stand at the Seasonal Working conference with our four quality priorities for this year. SM said she felt the 'triple excellent' the Trust scored should be published in larger font. CM asked about what would require funding. MAk said things like cards and 'pop ups'. CM felt that having money to fund a campaign would make people more interested, and having no money would make it more	

	difficult. MA invited views from the sub-committee on putting a bid for funding to the Council of Governors for the quality priorities campaign. After some discussion it was agreed that we should request £1000 per campaign i.e. £4,000 in total. The sub-committee agreed.	
	MAk to put proposal to the Council of Governors for funding.	**MAk**
	Proposals to be discussed and agreed at the Trust Executive Quality Committee.	**MA/MAk**
5	**Patient Experience Strategy and survey questions**	
	TD said that as discussed previously she is developing a Patient Experience Strategy. She said she was reluctant to send another questionnaire to staff as she thought she could use the responses we already have and we could use the survey in another way. The idea of a patient experience strategy was strongly supported.	
6	**Patient Safety Questions (FTGA)**	
	CM said that she was aware that this document had been circulated and we had prepared response to the questions posed in the document. This was tabled. MA suggested that VD resend the questions and our response to the sub-committee and invite responses back by the end of next week. We will then table the document for information at the Council of Governors meeting. CD suggested that this approach of questions and answers could be used for the Council to ask questions of the Board. CM suggested that CD discusses this at the Away Day in December where a focus will be on communication between the Board and Council. **Finalise the response to the FTGA questions and table for information at the Council of Governors meeting.**	**CM**
7	**Feedback from governors on patient experience**	**All**
	WMW gave a feedback from two pregnant women who relayed their experience in the Maternity Unit. The patient feedback about the Neonatal Unit was excellent. However, whilst spending considerable time with a baby in the Neonatal Unit the mother missed on meals and ate toast only. There was also positive feedback about the delivery although one mother felt that some midwives were very young and therefore inexperienced. One mother said she felt bullied because of not breast feeding. TD said that she will speak to the Head of Midwifery about these issues. She pointed out that a group was set up a year ago to look at patient care and improving relationship between patients and staff and the satisfaction rate. Some improvements have already taken the place. TD	

	also said that she will take the contact details of the mother who complained about the breastfeeding and will contact her. SS-G said that whilst spending some time in the governors Information Zone she had some positive views from two patients about their experience and they completed a comment card. However, one Dermatology out patient complained about waiting a long time (over 2 hours) to be seen by the specialist. TD said that we are looking at getting a buzzer like in some restaurants to alert patients when their appointment is due. WMW said she had a complaint from a patient about the Choose and Book system and said Chelsea and Westminster were notorious for not updating their consultant rotas. The patient was not booked to see the consultant she requested. In addition to that the appointment was subsequently cancelled. MA explained that the Choose and Book system has a limited number of appointments as opposed to contacting the reception directly to book over the phone. Similar to a GP's surgery the work is shared between consultants. MA said that most of the time individual requests are met. He commented that the Choose and Book system would not have an option of individual consultant's names appearing as just time slots are available. SM said she had passed a complaint to Sian Nelson from a patient who had had surgery and the tip of the cannula came off and he bled. He felt the nurses did not reassure him. SS-G said that there has recently been a case in the media re the death of a patient who was not fed. She asked if we considered media stories and responding with the position at C&W and publishing on the website. CM will raise with MAk but pointed out it may backfire if our position is no better. JT said that we are meeting with the lead dietician and the LINKs representatives to look at diet at C&W. TD said that there are some issues we have re nutrition of patients and a group is being set up to look at this including Charlotte Mackenzie Crooks' proposals for improvements.	
8	**Any other business**	
	None.	
9	**Date of next meeting – 17 November 2010**	

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 16 September 2010

AGENDA ITEM NO.	2.14/Sep/10
PAPER	Minutes of the Council of Governors Membership Sub-Committee meetings held on 2 September 2010 (draft)
AUTHOR	Vida Djelic, Interim Foundation Trust Secretary
LEAD	Chris Birch, Chairman
EXECUTIVE SUMMARY	Draft minutes are enclosed.
ACTION	To note.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Membership Sub-Committee, 2 September 2010

Draft Minutes

Attendees	Chris Birch	CB	Chairman
	Martin Lewis	ML	Public Governor – Westminster 2
	Susan Maxwell	SM	Patient Governor
	Wendie McWatters	WMW	Patient Governor
	Sandra Smith-Gordon	SS-G	Public Governor – Kensington & Chelsea 2
	Del Hosain	DH	Wandsworth 2
In attendance	Matt Akid	MA	Head of Communications
	Sian Nelson	SN	Membership and Engagement Manager
	Therese Davis	TD	Interim Director of Nursing
	Cathy Mooney	CM	Director of Governance and Corporate Affairs
	Jane Tippett	JT	Acting Assisting Director of Nursing
	Vida Djelic	VD	Interim FT Secretary

1	**Welcome and Apologies**	**CB**
	Apologies were received from Charlotte Mackenzie Crooks.	
	CB welcomed a newly elected public governor Del Hosain to his first meeting of the sub-committee.	
2	**Minutes of previous meeting held on 8 July 2010**	**CB**
	Minutes of the previous meeting were accepted as a true and accurate record of the meeting with the following changes: - on the attendance list against Jane Tippett change 'Assisting Director of Nursing' to 'Assistant Director of Nursing ' - p.3 insert '£' before the figure '15,000' - p. 4 SS-G volunteered to help with styling the information on the website to be transferred to p.5 - p.4 insert 3rd para insert 'being a governor and' before 'empowering patients' p.6 1st line 'would be' instead of 'was' and 'later' instead of 'earlier'	
	VD to amend the draft minutes as per comments received.	**VD**
	JT noted the minutes relating to the date of Seasonal Working conference was correct at the time but has now been changed.	
3	**Matters Arising**	**CB**
	7/Jul/10 Membership Development and Communications Strategy	

	Work Plan Review	
	4. Recruitment Campaign JT said that discharge leaflets were due to be discussed at a meeting which was cancelled due to an incident on the Acute Assessment Unit (AAU). TD will raise it with the ward staff.	
	8/Jul/10 Meet the Governors information booklet	
	MA asked for clarification on whom the booklet is aimed at. CM said that the governors handbook should contain information such as name, tel. number, e-mail address and a short profile of governors. It may be different to what is already published on the website under 'meet your governor' section as it is aimed to be shared between governors only. She reminded the sub-committee that this idea came from a meeting over a year ago about how to improve induction.	
4	**Membership Development and Communications Strategy Work Plan**	**SN**
	CB said that there are two documents, one is the strategy and the other is the work plan. As far as he was concerned the Membership Development Strategy is updated on a yearly basis. It was revised by the sub-committee in April this year and was approved by the Council of Governors at its meeting in April. He felt that it is not necessary to present it to every meeting of the sub-committee. Only the work plan updates should come to every sub-committee meeting. SS-G suggested it would be very useful to have a date published on the work plan every time it gets updated. **SN to update the work plan accordingly.** SN outlined the main changes to the work plan and these were as follows: **2. Seasonal Working Conference** SN said that she send an invitation to governors and invited them to help with the governors stand and has so far received 4 responses. She added that so far no governor has volunteered to give a presentation on the Council of Governors. She said that she will take it to the Council of Governors at its meeting on 16 September. CB asked if all governors were invited to attend the conference. JT said that governors were all invited before but on this occasion we did not invite all governors to attend as there are not enough spaces at the conference. She added it was the intention that this should happen annually and will be open to all governors. **3. Patient Forums** SN said that CB has applied to become a member of HIV forum. WMW was accepted to the membership of the Children's forum. SN tabled a copy of an outpatient survey and invited the sub-committee to comment on the content. CB suggested that there needs to an introduction. SN said that Alex Prior, Outpatient Services Improvement Manager, designed the questions for this questionnaire. CM asked whether it had taken into account the outpatient services vision and suggested Hannah	**SN**

	Coffey, Director of Operations, is asked for comments and input. SN said that the intention was that the survey will be sent to 3000 members by email. TD asked SN how she plans to reach people who do not use e-mail. She said that this needs to be considered including all groups of people. JT commented that Alex Prior is a member of the Outpatient Steering Group. She commented that the order of questions should be prioritised. CM suggested that q.7 was a waste of question as there was only one sensible answer. SS-G said she felt that this survey was a very internal document and it complicates it by asking the governors. TD said we need to get it right first internally. **7. Website** SN said that the first meeting of the FT section of the website task and finish group was held earlier today. **10. Reaching underrepresented groups in the Membership** SN said that she has emailed governors and invited one governor to join the Mobile Health Steering Group. WMW volunteered. There is a Teddy Bear picnic project in progress and the detailed plan will be presented to governors. **11. Young Persons Membership Group** SN said that the Birmingham's Hospital has 10 years plus members and this membership category was approved by Monitor. SN plans to visit the hospital later in September. SN said that the Westminster School will have a stand at the Annual Members' Meeting on 16 September. SN said that she will be representing the MPALS service at the Kensington and Chelsea Learning Disability Community Health Fair on 15 September and governors are welcome to attend. CB said that under the named personnel the following amendments need to be done: - against TD insert 'Interim' before 'Director of Nursing' - reinstate BG considering that he appears under actions list - remove Jim Smith **SN to amend the named personnel list as per comments received.**	
5	**Signage – Redevelopment of the hospital**	**ML**
	Mark Lynn, General Manager - Estates and Facilities introduced himself. He said that there are a lot of developments going on and departments moves are under way and considering this we need to change the signage	

	around the hospital appropriately as it is currently out of date. MLn said that the short term plan is to temporarily arrange signage so that it is easy to navigate around the hospital. The long term plan would be to introduce new technology to deal with departments moving, so that signage can be updated easily. ML said that he is going to set up a small group to look at modern signage which will consider airports, stations and possibly talking signs to help those who are partially sighted. We will also consider foreign visitors/patients. In response to CB's question about the timeline ML responded that a short term plan will have to be completed by this financial year. The working group will consist of TD who will be the Chair, nursing representatives, clinical teams, patients, ICT, estates and finance representatives. TD said that before the group is up and running some preparatory work needs to be done. ML invited two governors to be involved. In response to DH's question about the cost implications ML said that it depends on the technology we want to use and if we get sponsorship. MAk suggested we involve some representatives from the reception desk, volunteers and the security. He said he would also like to be involved e.g. to look at branding and sponsorship as he has experience in this area. . CB, SM and SS-G said they would like to be involved in the project. SN suggested a patient representative from a learning disability group should be involved.	
	ML to involve CB, SM and SS-G once the Group has been set up.	**ML**
6	**StartHere – Piloting a Patient Information Service**	**LH**
	Lucy Hadfield reminded the sub-committee that a short paper regarding piloting of a Patient Information System was presented briefly at the last Council of Governors meeting and it was decided that more detailed presentation will be given at the membership sub-committee in September. She introduced Sarah Hamilton-Fairly and Anna Biddle of the Chiswick based charity StartHere. She said that this is the opportunity to enter into partnership with StartHere Charity at a low cost to build on improving patient experience. SH-F outlined her background and how the Charity was set up 17 years ago. The Charity has a development contract with the NHS Choices and is a technology-based information service that acts as a single starting point from where people choose to access the information and services they need in times of crisis, distress or important life decisions. . SH-F said that the main benefits of the patient information system are	

	improving patient choices, satisfaction and it narrows inequality. In response to SM's question about how often the database is updated SH-F responded that there are 18 employees who work on a daily basis on updating information and confirmed that every record is updated once a year. TD said she thought that the idea is very good and that SH-F may want to consider having information available in different languages. SH-F said at the current stage it is available in the audio format but will certainly consider translating the information. TD said that there is also a lot of work to be done about hard to reach groups. TD described apps on the iPAD and how there is a message indicating an update and whether this could be considered. TD suggested that the system can also be linked to the hospital's bedside information e.g. TVs. LH said that the executive team had a very positive reaction about the project and decided that we take it forward. She said that putting it on the kiosks can be a first step. LH suggested we get 1 or 2 champion(s) from the Council of Governors to help with the project. It was suggested that VD will e-mail the Council of Governors and invite volunteers to join the project. The sub-committee thought this was an excellent concept.	
	VD to e-mail the Council of Governors and invite 2 volunteers to join the project.	**VD**
7	**Annual Members' Meeting**	**MAk**
	MA said that the Annual Members' Meeting will be held on 16 September and SS-G had kindly volunteered to give a presentation on the membership. MA suggested that governors encourage members as much as possible to attend the Annual Members' Meeting. SN confirmed that there will be a Council of Governors stand at the meeting. CB raised the issue of governors' badges being very small and suggested that a bigger size would be more appropriate. SS-G offered to make rosettes for governors so that members attending the meeting can differentiate governors from other attendees.	
8	**FT Section of the website**	**CM**
	CM informed the sub-committee that a first meeting of the FT section of the	

	website Task and Finish Group meeting was held earlier today and there are actions. She said that there are three areas that need to be looked at: - future structure - existing content and new content - writing of the new content VD tabled the timetable list for the Autumn elections and a list of seats expiring in December and those that are currently vacant. CM informed the sub-committee that we need to run elections at the beginning of October and we need to think how we generate interest in elections from patients and public and also how we publicise it. SN and the Capita recruiters will be involved in the elections promotion.	
9	**Patient Experience section of the website**	**SN**
	SN said that the plan is to rename the section on the hospital website so that it is more about patients visiting the hospital. Patient Experience section will be more about improving patient experience, patient forums and how to get involved. The Annual Survey Questionnaire will be added to this webpage. SM suggested that on this section there should be a link to infection control as patients are interested in the MRSA rate.	
10	**Election of the Chairman of the Membership Sub-Committee**	**CB**
	CB informed the sub-committee that he would like to step down as the Chair of the Membership Sub-Committee. He commented on the paper written on the election of the chair of the sub-committee and said that as stated in the Terms of Reference of the Membership Sub-Committee the Chair would get elected at the meeting of the sub-committee not before the meeting and felt that nomination deadline should be open till the next meeting of the sub-committee. CB invited views of the sub-committee on this. The sub-committee discussed the issue raised by CB and agreed that the procedure for election of the chairman of the membership sub-committee proposed by VD will be accepted for practical reasons and agreed that the Terms of Reference need changing. **VD to amend the Terms of Reference as agreed by the Membership Sub-Committee in preparation to the next review.** The sub-committee also agreed to have a deputy Chair so that when it happens that the Chair is unavailable or in case of resignation there is a representative who would chair the meetings until the next chair is elected. The Sub-committee agreed to have a deputy chair. **Governors to send their nominations for the Chair and Deputy Chair of the Membership Sub-Committee to Vida Djelic by 24 September.**	**VD**
11	**Membership ideas – funding**	**SN**

	SN said that she has had approval from the Council of Governors in July for the funding for the display of board in the Information Zone. She asked if the sub-committee would support the proposal for supply of one maple table and two chairs. CB reminded the sub-committee that £45k is left in the Council of Governors budget to be spent for the remainder of the year. The sub-committee discussed the proposal and the vote took place. 3 governors disagreed and 2 agreed with the proposal. It was therefore confirmed that the proposal will not be put forward to the Council of Governors. SN said that the second proposal for funding was to purchase an awning for the Mobile Health Clinic which will provide coverage and some privacy to the area where she, recruiters and governors will be engaging with public. The sub-committee agreed that it is a good idea and supported the proposal which will be taken to the Council of Governors for approval.	
12	**Any Other Business**	
	SS-G suggested that all papers sent to the sub-committee have at the end name of author and date. CM said that there were clearly defined rules when writing papers for the Board and we will be happy to adopt the same rules for the Council of Governors and its sub-committees.	
13	**Date of next meeting**	
	The next meeting will be held on 11 November 2010 at 4pm.	

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 16 September 2010

AGENDA ITEM NO.	2.15/Sep/10
PAPER	Membership Development Action Plan
AUTHOR	Sian Nelson, Membership and Engagement Manager
LEAD	Sian Nelson, Membership and Engagement Manager
SUMMARY	The Membership Development Action Plan has been updated by the Membership Sub-Committee.
DECISION/ ACTION	The Council of Governors is asked to note that Action Plan.

Chelsea and Westminster Hospital NHS Foundation Trust

MEMBERSHIP DEVELOPMENT ACTION PLAN

2010 – 2011
Updated September 2010

This action plan is based on the Membership Development and Communication Strategy that is designed to ensure the Trust has a vibrant and representative membership. The action plan outlines key actions for the forthcoming year to deliver the strategy and will proved a frame work for the Membership Sub-committee to monitor membership development activity and to report to the Council of Governors.

ISSUE	OBJECTIVE	ACTION	LEAD	DATE DUE/ COMPLETION STATUS	NOTES
1. Information Zone	To improve communication between Members and Governors within the Council of Governors dedicated information zone in the hospital.	• Develop open, drop in sessions for members and potential members to meet Governors • Develop a roster for Governors to be present in the zone to perform question and answer sessions Advertise/give notice to patients, public and staff of such events • Erect pictures of Governors in the Information Zone with contact details of each Governor.	CB SN	08/05/10 ACHIEVED – TIMETABLE FOR INFORMATION ZONE ROSTER.	To be launched at the Annual Open Day, 8th May 2010. A Governors session timetable has been published for August and September 2010. Sent to Members with August Trust News.
2. Seasonal Working Conference for Hospital Staff	To create a forum through which Governors can communicate with Members on key issues of patient care.	• Governor presentation at the Seasonal Working Conference • Governor stand at the Seasonal Working Conference • Invite a group of Members to the Seasonal Working Conference through the bi-annual mailings or email.	TBC		To commence at the Summer Seasonal Conference July 2010 Governors invited to present 'The role of a Governor' at the October Seasonal Working Conference. A Governors exhibition stand will be set up.
3. Patient Forums	To actively participate in patient forums to receive direct feedback from patients users.	• Governors to participate in chosen patient forum • Governors to feedback important messages to the -appropriate Council of Governors Sub-Committee and action plan as appropriate • Governors to sign to forum to acknowledge participation • Establish relationship with local LINks	TBC	May 2010	Chris Birch has applied to become a member of the HIV Forum. The forum membership will consider his application. Wendy McWatters has been accepted to the Children's, Young Person's and Families Forum. The next meeting date is to be confirmed.

ISSUE	OBJECTIVE	ACTION	LEAD	DATE DUE/ COMPLETION STATUS	NOTES
4. Recruitment Campaigns	To recruit new members to all constituencies and aim for a representative membership.	• Membership Sub-Committee to review membership bi-monthly and identify opportunities for recruitment and agree a recruitment plan and funding for 2010/11 with the Council of Governors.	TBC		
5. Bi-annual membership mailings	To effectively use the bi-annual membership mailings to inform the membership of key issues and explore how the Trust can elicit feedback from members	• Sub-committee to agree the purpose and content of each mail shot • Trust News to be sent to all members bi-annually. The content of the member's Trust News should target patients and the public as well as staff. • Ensure Membership engagement is a priority in membership mailings. Requests to members for their feedback on specific issues or invitations to the Trust should be integrated in each mail shot. • Update members on developments of the hospital and consult with members on key Trust issues for example the hospital extension.	SM SN RMcB		A questionnaire has been designed to consult members re out-patients move. This will firstly be approved by the Out-Patients Improvement Committee before approval is sought from the Council of Governors in December 2010.
6. Email communication with Members	Establish an effective use of email communication with Members	• Sub Committee to agree purpose and content of email communication • Update Members email details and encourage use of email in membership literature • Send regular and targeted emails (inc.		April 2010	First members email circulation sent June 2010 requesting members to support the abolition of the congestion zone charge. Members' emails updated June 2010. Approximately 3,200

ISSUE	OBJECTIVE	ACTION	LEAD	DATE DUE/ COMPLETION STATUS	NOTES
		Trust News link) with Trust updates • Send requests for patient involvement as requested by Trust committees, for example, PEAT, or other patient panels			members email addressed. (updated September 2010)
7. Website	To utilise the C&W Hospital website to promote membership involvement and the Council of Governors To ensure Members feel involved in Trust activities.	• Membership Sub-Committee to work with the in house team to refresh web pages, e.g. Clear identification of Governors and the constituencies they represent; Explanation of the role of the Governor; Clear process for contacting Governors • Members feedback box for Governors response • On-line Members application form content to reflect the new paper application form • Develop a Members page to provide information regarding Members events and other Trust invites or activities.	TBC		In progress – Patient Experience Web Page.
8. Council of Governor Elections	To ensure members have the information they need to confidently stand for elections	• Agree through the Membership Sub-Committee types of events to support members with the election application process	CB SN	May 2010 Achieved – Members Election Work Plan	

ISSUE	OBJECTIVE	ACTION	LEAD	DATE DUE/ COMPLETION STATUS	NOTES
9. Staff Constituency	Encourage staff representatives to agree an annual program of events with staff members including meetings.	• Agree annual program of events e.g. meetings, column in Trust News. .	CD, LB, JJ, BG, SS	Commence April 2010	Carol Dale, Staff Governor for the management constituency has established this approach in her constituency and her method can be applied to the other staff constituencies.
10. Reaching underrepresented groups in the Membership	To improve representation of under-represented groups	• Membership Sub-Committee to review membership bi-monthly and identify underrepresented groups and agree plans for recruitment and engagement in these groups. • Target ethnic minority groups in the community and seek ways of engagement with these groups. • Governors to link with the Mobile Health Clinic Steering group to reach groups in the local community	ALL ML SN		The mobile community clinic at Chelsea Football Club reaching the male population. Similar project to start at Queen's Park Rangers in September 2010. Sian to meet with QPR. Governors have been invited to attend events with the West London Sexual Health Clinic events in the community Invitation for Governor representation to the Mobile Health Clinic Steering Group – August 2010 Governor WMcW: Teddy Bears Picnic event plans in progress date 30th September 2010. Paper submitted for the Membership Sub-Committee 2nd September 2010

ISSUE	OBJECTIVE	ACTION	LEAD	DATE DUE/ COMPLETION STATUS	NOTES
11. Young Persons Membership Group	To create a Young Persons Membership Group to strengthen the membership of young people	• Membership Sub-Committee to agree a proposed 'terms of reference for the group' • Propose the idea of a Young Persons Membership at the next Annual Members Meeting. • Identify a Young Persons 'Champion' to lead the membership group. • Work with the existing children's forums to understand how we can gain insight into the needs of this group, reach this group and offer membership for their benefit • Visit to schools to provide education sessions for young people and link with membership. For example, providing first aid classes or sexual health awareness.	ML SN SM		Westminster School boys summer project to commence in July 2010. Human resources to support a group of 8 boys who will be split into 2 groups. Group 1 to look at ways to improve the patient experience. Group 2 to advise how the Trust can engage with young people. Boys to present the project at an exhibition stand the Annual Members Meeting 16th September 2010. Membership and Engagement Manager to visit Birmingham Children's Hospital in September. BCH have age 10+ Members constitutional approval by Monitor.
12. Quality Accounts	To engage members and seek feedback of the Quality Accounts	• Governors to seek the views of members regarding the Trusts Quality Accounts through engagement activities: mail shots, email/website, seasonal working conference and the Governors session in the Information Zone	SN		To discuss with LINks who provide similar training for LINks members to review Quality Accounts.
13. Learning Disability Strategy	To involve members with the	• To create a learning disability patient forum to seek feedback from members with a learning disability with regards to	SN	In progress	Membership and Engagement Manager has met with Hammersmith and Fulham

ISSUE	OBJECTIVE	ACTION	LEAD	DATE DUE/ COMPLETION STATUS	NOTES
	implementation of the Learning Disability Strategy	support services, information including leaflets and signage • Share the forum with external agencies (for example, LINks) in the community to gain feedback from the local community of the expectations of the Trust			Learning Disability Carer's group to discuss needs of carer's. To arrange to attend Learning Disability User's Group, such as Men cap. Steering Group Committee to meet in September 2010. MPALS will have a stand at the Community Learning Disabilities Health Fair 15th September 2010. with Royal Borough of Kensington and Chelsea.
14. Service Development	To consult members on service development activities	• Consult with members on service development within the Trust, for example the extension and redevelopment of the hospital. Request feedback through mail shots, email/website seasonal working conference and Governors sessions in the Information Zone	SN		Members have been consulted with regards to the abolition of the congestion zone charge via email. Out-patient consultation questionnaire to be sent to Members after approval from Council of Governors 16th September 2010

Updated September 2010

Named Personnel:

TD	Therese Davis	Interim Director of Nursing, Chelsea and Westminster
CM	Cathy Mooney	Director of Governance and Corporate Affairs
SN	Sian Nelson	Membership and Engagement Manager/MPALS
VD	Vida Djelić	Foundation Trust Secretary
MA	Matthew Akid	Communications Manager
JT	Jane Tippett	Acting Assistant Director of Nursing
CB	Chris Birch	Patient Governor and Chairman of the Membership Sub-Committee
SM	Susan Maxwell	Patient Governor
SSG	Sandra Smith Gordon	Public Governor, Kensington and Chelsea Area 2
ML	Martin Lewis	Public Governor Westminster Area 1
BG	Brian Gazzard	Staff Governor, Medical and Dentistry
CD	Carol Dale	Staff Governor, Management
JJ	Jacinto Jesus	Staff Governor, Contracted
LB	Lucy Ball	Staff Governor, Allied Health Professional, Scientific and Technical Staff
SS	Sue Smith	Staff Governor, Nursing and Midwifery
RMcB	Renae McBride	Communications Manager
WMcW	Wendy McWatters	Patient Governor

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 16 September 2010

AGENDA ITEM NO.	2.16/Sepl/10
PAPER	Membership Report
AUTHOR	Sian Nelson, Membership and Engagement Manager
LEAD	Therese Davis, Interim Director of Nursing
SUMMARY	This paper reports on the membership numbers for the Trust which currently has a total membership of 15,041.
DECISION/ ACTION	For review of the Council of Governors.

Council of Governors Membership Report

1.0 Introduction

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

2.0 Background

2.1 Member Constituencies

2.1.1 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 15 July 2010.

	MEMBERS	PERCENTAGE
Staff	3,091	20.6%
Patient	5,975	39.7%
Public	5,975	39.7%
Total	15,041	100.0%

Table 1: Membership

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

2.2 Patient Constituency

2.2.1 Patient members for 2010/11 are currently at 5,975. The number of patient members who have left from 1st April 2010 currently stands at 294. The reasons for members leaving is generally either because of movement of address outside of the eligible constituency, or death. A total of 259 new members have joined since April 2010.

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

Age (Years)	
0-16	0
17-21	58
22+	3,164
Unknown	2,753

Table 2: Patient membership by age range

2.3 Public Constituency

2.3.1 The Trust's target is to maintain the size of membership in the public constituency in 2010/11. Currently we have 6,052 public members, against 6,131 in 2009/10. To date there have been 113 new members since April 2010, with 179 members leaving membership.

2.3.2 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.

PUBLIC CONSTITUENCY	NUMBER OF MEMBERS	ELIGIBLE POPULATION	INDEX
Age (years)			
0-16	0	6,154	0
17-21	59	40,632	18
22+	5,138	709,475	91
Unknown	778		
Ethnicity			
White	4,225	581, 753	91
Mixed	242	28,772	106
Asian	339	48,323	88
Black	228	67,208	54
Other	295	29,947	124
Socio-economic groupings			
ABC1	5,155	431,344	151
C2	4	40,531	1
D	0	63,223	0
E	795	87,991	114
unknown	21		
Gender analysis			
Male	2,363	362,544	82
Female	3,562	393,249	114
Unknown	50		

Table 3: Analysis of Public membership

2.4 Staff Constituency

2.4.1 Staff membership has been updated to include all staff

STAFF CONSTITUENCY	
1 April 2010	3.046
New Members	611
Members leaving including (Opt Out)	566
August 2010	3,091

Table 4: Staff constituency figures.

3.0 Content

3.1 Membership Recruitment and Engagement

3.1.1 Since April 2010 a total of 1,129 members have left membership and 983 have joined. Membership recruitment is managing to maintain numbers.

3.1.2 The Membership Development Sub-Committee of the Council of Governors develops and reviews the Membership Development and Communications Strategy.

3.1.3 A Membership Action Plan 2010-11 has been circulated to the Council of Governors. This provides direction and feasible actions for Governors to increase membership for the forthcoming year. The Action Plan 2010-11 emphasises engagement between the Governors and Trust with Members. This is reviewed bi-monthly at the Membership Sub-Committee meeting.

3.1.4 The Membership – Patient Advice and Liaison Services support membership promotion and any visitor to the M-PALS office will receive a membership application form. The forms are sent with all patient response letters from M-PALS.

3.1.5 A member's email database has been updated with over 3,000 emails registered. This will be used for low cost, rapid response membership consultation.

3.1.6 A discharge booklet, funded by the Council of Governors is given to patients on admission and includes a membership application form.

3.2 Developing a Representative Membership

3.2.1 Analysis of the membership database by age, gender and ethnicity ensures we work towards representative memberships within the communities we serve. Actions taken to ensure representative membership include:

3.2.2 MPALS will attend the Kensington and Chelsea Learning Disabilities Health Fair on 15th September 2010. The Trust will show the new learning disability easy read leaflets, as well as the newly designed Learning Disability Passport. Membership recruitment will take place using the new Learning Disability Membership Application Forms.

3.2.3 The Trust has purchased a community mobile health clinic. This was set up with the aim of membership development and engagement in the community. The services from the mobile health clinic aim to target 'hard to reach' groups in the community.

3.2.4 The Membership and Engagement Manager with a Governor attend the Mobile Health Steering Group. They look closely how Governors can link with Trust activities in the community (especially where membership is underrepresented) and decide on appropriate outreach services for these areas.

3.2.5 Membership under-representation continues in the following areas:

- Low penetration in the Public: Wandsworth 1 constituency
- Significantly lower membership in the under-40 age group
- Lower membership in the Black and Asian ethnic groups.

3.2.6 The Council of Governors and Foundation Trust Members are invited to attend the Annual Members' Meeting in September 2010 to give their views on the Trust.

3.2.7 Patient Governor Wendie McWatters with the Membership and Engagement Manager has organised a Paediatric event in the Kensington and Chelsea Area 2 constituency (30th September 2010). The event will highlight the expansion of the Paediatric services and invitations will be sent to local families and children from a diverse range of schools in the local community.

The Mobile Health Clinic will be parked and a variety of health promotion activities will take place, as well as stands from community parent support groups.

3.2.8 Throughout the summer of 2010 Westminster School boys have undertaken a project looking at the patient experience at Chelsea and Westminster Hospital. They will exhibit the project at the Annual Members Meeting on 16th September 2010.

3.2.9 Five Governors will be present at the Seasonal Working Conference on October 12th 2010. One Governor will present on the 'Role of the Governor' and a stand will be set up for a group of four Governors.

3.2.10 Governors from the Membership Sub-Committee host 'Meet a Governor' session at the Ground floor Information Zone. Patients, public, staff and members have the opportunity to meet a Governor to discuss issues important to them. This is publicised on the Trust website and a session timetable was sent in the members mailing in August 2010 to promote the sessions.

3.3 Election Plan

3.3.1 Chelsea and Westminster Hospital Foundation Trust plan for the Autumn Governor Election in October 2010. Elections will be held in the following constituencies

PATIENT GOVERNORS SEATS	PUBLIC GOVERNOR SEATS	STAFF GOVERNOR SEATS
2 seats	Westminster 1	Nursing & Midwifery
	Westminster 2	
	Wandsworth 1	

Table 5: Election seats for nomination

3.3.2 **Key election dates:**
Publication of notice of election: 1st October 2010
Close of Poll: 26th November 2010
Election results: 29th November 2010

3.3.3 An election promotions plan will be devised to ensure that all patient, public and staff constituencies are aware of the election, to create equality and clarity of the application process.

4.0 Summary

4.1 Membership engagement is a priority for 2010-11. The Membership and Engagement Manager encourages Governors to engage further and more meaningfully with their constituencies. Increasing representation in all areas is important, and encouraging growth in hard to reach communities. The Membership Work Plan 2010-11 outlines direction for development.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 16 September 2010

AGENDA ITEM NO.	2.17/Sep/10
PAPER	The White Paper, Equity and Excellence: Liberating the NHS - Key Elements related to Chelsea and Westminster Hospital FT's Strategy
AUTHOR	Lucy Hadfield, Interim Director of Strategy and Service Planning
LEAD	Heather Lawrence, Chief Executive
SUMMARY	This paper sets out the key elements of the coalition Government's health White Paper (and associated documents), and how those elements relate to Chelsea and Westminster's current strategy. The White Paper has at its heart three key principles: • patients at the centre of the NHS • changing the emphasis of measurement to clinical outcomes • empowering health professionals, in particular GPs. It proposes radical changes to where power sits in the system, replaces much of the existing hierarchy and moves from quasi-markets that were often really just managed systems to full blooded market mechanisms with reduced system management. Extensive patient choice and provider competition will be key drivers. It also represents an attempt to reduce political involvement in the micro-management of the system and the way that the NHS is held to account for its performance. Finally, it involves a very large structural reorganisation of the NHS. White Paper draft legislation will enter Parliament in the autumn. Subject to parliamentary approval, the Bill could receive Royal Assent by summer 2011. The Department of Health has a set of consultation papers on most of the key elements outlined in this paper. These are available together with details of how to respond to the consultations in a dedicated section of the Department of Health website: www.dh.gov.uk/liberatingthenhs In terms of our governance, performance and reputation, we are

	currently in strong position as an experienced Foundation Trust to embrace and tackle the challenges and opportunities the new system presents to our patients, members, staff and local partners. Our current corporate objectives and CIP are still largely appropriate for the new policy environment, though will be reviewed by the Board. We will continue to analyze further White Paper developments and act through the annual planning process this autumn and winter.
DECISION/ ACTION	Governors are asked to note and comment on this paper.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

The White Paper, Equity and Excellence: Liberating the NHS - Key Elements related to Chelsea and Westminster Hospital FT's Strategy

1 What has not changed –Core Principles, Outcomes and QIPP

There are important continuities with the previous vision. It is the levers and structure of the system, i.e. the means, and not the ends, will change.

NHS core principles will be upheld - a comprehensive service, available to all, free at the point of use, based on need, not ability to pay. The whole system will be dedicated to improving quality and outcomes, i.e. mortality, morbidity, safety, patient satisfaction.

The need to achieve £15 to 20 billion efficiency savings for reinvestment in the NHS remains, though the emergency budget did not increase financial reductions for the NHS. The national QIPP (Quality, Innovation, Productivity and Prevention) programme remains in place.

Chelsea and Westminster Hospital's Strategy

Our current corporate objectives firmly reflect these three constant themes and should remain consistent

2 The Design of the New System

The key elements of the new system are outlined below:

2.1 Patients and Public - Informed Choice

The new system will require a revolution in NHS information. 'Patients need and should have far more information and data on all aspects of healthcare, to enable

them to **share in decisions** made about their care and find out much more easily about services that are available.' Patients will have control of their own records and comparative information about performance of providers will be made even more readily available. This will enable increased choice and control by patients over their care and treatment and also acceptance of increased personal responsibility for the choices. Extension of choice will be for:

- GPs
- Named consultant-led teams
- Maternity
- Diagnostic testing
- Mental health
- Long term conditions
- End of life
- Any willing (licensed) provider, where relevant

The collective patient and public voice will also be strengthened by Health Watch England, a new networked consumer champion. Patient choice will be translated into legitimate commissioning decisions mainly at local level through new, strengthened GP consortia.

Chelsea and Westminster Hospital's Strategy

We have some of this vision in place as a foundation trust with a wide network of members. Current relevant plans and initiatives include a new patient experience strategy, an information strategy, the appointment of a director of patient flow, a comprehensive directory of services, improvements in use of Choose and Book (the electronic hospital appointment booking service), improvements to our website and the introduction of StartHere, an easy to use electronic public information service. There will be much more to achieve and innovation in this area will be key to our competitive advantage. We anticipate further policy in this area.

2.2 GP Commissioning

GP consortia will replace PCTs as the key local health commissioners. They will work closely with local authorities. GP consortia will be more autonomous, yet more accountable to a new NHS Commissioning Board, operating at arms length from Government. There are major questions about how effectively GPs will be able to control finances and address decisions about priorities. These are around capability and capacity, assurance, running costs, their motivation to engage and lead, competition and commercial probity of GP practices and equity for 'hard to reach' populations. The design and legality of GP consortia has yet to be determined.

Chelsea and Westminster Hospital's Strategy

We have good relationships generally with GPs whose patients we see and with GP leaders. We have increased the priority of relationship management and we are planning an engagement event for all GPs in October. We will support GPs to become effective commissioners.

2.3 NHS Commissioning Board and Outcomes Framework

The Commissioning Board will lead the new system, allocate and account for NHS resources, set an outcomes framework and hold GP consortia to account. The outcomes framework will be structured around five domains that the NHS should be delivering for patients covering effectiveness, patient experience and safety:

- Preventing people from dying prematurely (effectiveness).
- Enhancing quality of life for people with long-term conditions (effectiveness).
- Helping people to recover from episodes of ill health or following injury (effectiveness).

- Ensuring people have a positive experience of care (patient experience).
- Treating and caring for people in a safe environment and protecting them from avoidable harm (patient safety).

It will improve quality through:

- The National Institute of Clinical Excellence (NICE), (which will remain with a strengthened role) developing 150 sets of quality standards
- supporting research
- reforming the Payment by Results (PBR) tariff system to better incentivise providers towards desired outcomes, thought this will overlap with the role of Monitor, the economic regulator (see below)
- CQINs will grow in significance (these are quality related deliverables within generic hospital contracts, with funding attached, 'Commissioning for Quality and Innovation')

The scope and accountability relationships of this Board with other parts of the system are yet to be determined.

Chelsea and Westminster Hospital's Strategy

We are focusing on measurable improvements in outcomes and getting ready for increasing amounts of information about those outcomes to be available. The guidance has indicated that maternity and some children's services would be commissioned at national level, rather than by GP consortia. This could have negative consequences for the Trust and we will work to influence this decision. We will also aim to influence decisions about how the commissioning of our specialist services is done, e.g. burns.

2.4 Providers

The new system will also give greater autonomy and freedoms to providers over income generation, investment, borrowing and governance, beyond those of existing foundation trust (FT) status. All NHS trusts will become FTs by 2013 and operate as social enterprises. They will be equal in the NHS market place to private and voluntary providers, neither protected nor restricted. The cap on other sources of income will be lifted e.g. from private patients, and a broader scope of operations will be allowed. These developments are a logical extension to the existing FT policy. There are big challenges ahead in bringing all Trusts to FT status and creating a true market level playing field.

Chelsea and Westminster Hospital's Strategy

As an experienced FT, we have an advantage in a more open market and will need to increase our activity to maintain it. The majority of Trusts in our sector are not FTs and structural change will be needed to make the transition. The process to get there is not clear, but it is likely that we will have the opportunity to acquire other trusts and/or services. This is already a consideration in our strategy.

2.5 Regulation

All providers will be governed by a rules-based system of regulation. Monitor will become the economic regulator for the health and social care sectors promoting competition and supporting commissioners to give continuity of service. It will have a wide range of increased powers that are currently vested in the Department of Health and Strategic Health Authorities and these may come into conflict with other parts of the system, particularly splitting responsibilities with the Commissioning Board. The Care Quality Commission (CQC) will be the sector quality inspectorate of providers. Monitor and CQC will jointly license providers to assure essential levels of safety, quality and service continuity. The aim is that the overall system should to be much

closer to the type of markets found in the regulated utilities. Competition law will apply.

Chelsea and Westminster Hospital's Strategy

The transition to a new regulatory system is likely to be challenging and we will need to be alert to the risks to our reputation of an unpredictable process of assessment in the short term. Measurement will become increasingly care pathway-based and our strategy reflects the need to develop services that are more integrated with the community.

2.6 Public Health, Social Care and Democratic Legitimacy

The public health budget will be separated from the NHS and there will be a separate outcome framework for public health and social care. There will be a reformed arms length body responsible for national public health and safety functions. Democratic legitimacy in the NHS will be strengthened by creating local health and well-being boards (HWBs) in local authorities with its appointed director of public health and ring-fenced budget, and by changes to patient and public engagement (PPE) arrangements at local and national levels. These changes will promote greater integrated working between NHS commissioners and local authorities, replacing existing local partnership arrangements and work with the local strategic partnership.

HWBs can also agree joint NHS and social care commissioning for particular services or plan the allocation of place-based budgets. New arrangements for PPE include the creation of (HealthWatch England) and local HealthWatch, which will be based on existing Local Involvement Networks (LINks). In addition to LINks' existing powers and functions, Local HealthWatch will have a seat on the HWB and can report concerns to HealthWatch England or the commissioning board.

Chelsea and Westminster Hospital's Strategy

As we develop services extending across the pathway into the community for both children and adults, we will need to increase our engagement with HWB's in addition to GP Consortia. Links with local partners in the 'Total Place' concept may give opportunities for greater efficiency.

The following themes are also very significant for the design of the new system:

2.7 Freeing up Health Professionals

The principle of autonomy will also extend to healthcare professionals and staff. They will lead education commissioning, working with their employers. All providers will pay to meet the costs of education and training so that there is a true level playing field amongst providers. Academic Health Science Centres remain part of the structural landscape, but no further development of the vision is made. Further policy is expected on the position of education, training and research in the system.

Chelsea and Westminster Hospital's Strategy

We are continuing to strengthen clinical leadership across the main professional groups. We will anticipate further policy guidance and will enable our staff to engage.

2.8 Streamlining Bureaucracy and the Future of Arms Length Bodies

The Government is committed to reducing NHS administrative costs by more than 45% over four years and to simplify and reducing radically the number of NHS bodies. This should have the benefit of freeing up the front line of the NHS to improve

efficiency and effectiveness. The future of the existing 18 arms length bodies has been review. Several will be abolished and the functions of others handled in different arrangements within the new system. The abolition of SHAs and PCTS is also a streamlining measure. However, the administrative costs of the new system e.g. the costs of managing information to underpin the outcomes frameworks, commercial transactions and regulation, are as yet unknown.

Chelsea and Westminster Hospital's Strategy

Our strategy addresses the need for increased efficiency in overhead costs. We welcome a greater proportion of NHS resource being available for direct care.

2.9 Managing the Transition

The greatest challenge posed by the White Paper is in its implementation by 2015. The scale of the transformation is huge, whilst ensuring continuity of service and financial control. The signals of reductions in NHS management organisations and their management staff could lead to an exodus of the very skills needed to lead the transition.

The status of NHS London's leadership for the immediate future in the light of the White Paper, and its ability to continue with implementation of much of its strategy 'Healthcare for London' through sectorisation, is uncertain.

Chelsea and Westminster Hospital's Strategy

We will continue to work constructively with all partners and increase our awareness of the risks to the Trust of a bumpy transition nationally and within the sector.

Lucy Hadfield
Director of Strategy
5th September 2010

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 16 September 2010

AGENDA ITEM NO.	3.1/Sep/10
PAPER	Finance Report – July 2010
AUTHOR	Kelda Alleyne, Deputy Director of Finance
LEAD	Lorraine Bewes, Director of Finance and Information
EXECUTIVE SUMMARY	The Trust plan for the 2010/11 financial year is to earn income of £318m and achieve a profit measured by EBITDA (Earnings Before Interest, Depreciation & Amortisation) of £30.9m and a surplus of £12.4m. The Trust has achieved a surplus of £4.8m at month 4 which is £0.9m (21.5%) ahead of plan. EBITDA was £10.4m which is £0.3m (3.3%) ahead of plan. However, within this position there is a benefit of £1.0m income relating to 2009/10 activity. Therefore the underlying position for the period ending month 4 is a net £0.1m adverse variance against plan. Pay is £0.4m over-spent against budget YTD, which includes unidentified CIPs (Cost Improvement Programmes) built into the budget phasing. After salary recharges, the pay position is broadly on target (£0.2m over-spent against budget). Non-Pay is £0.6m over-spent against budget YTD, due to unidentified CIPs within budget position (£0.5m); increased costs for Pathology (£0.3m); and increase in bad debt provision (£0.3m) to recognise potential challenges from PCTs relating to outstanding debt. These over-spends have been partially off-set by costs for drugs being lower than originally planned (£0.3m). For 2010/11 the Trust has a very challenging CIP target of £22.6m (10% of controllable spend) and has identified 81% so far, of which 73% is achieved or low risk and 27% medium and high risk. The Executive will continue to work with Services to identify further CIPs in order to fully achieve the 10% target. The Trust is currently forecasting a year end surplus of £8.9m and EBITDA of £26.4m, both lower than plan. The Trust Executive is working with Clinicians and Management to continue identifying further CIP's and Income to ensure the Trust achieves it's financial targets for 2010/11.
DECISION/ ACTION	The Council is asked to note the financial position for the 4 month period to 31st July 2010 and the updates in this report.

CHELSEA & WESTMINSTER HOSPITAL NHS FOUNDATION TRUST

CONSOLIDATED INCOME & EXPENDITURE SUMMARY

Responsibility: Finance Director

TRUST WIDE

FINAL - LEDGER CLOSED

	THIS MONTH			YTD			FULL YEAR		
	BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE	CURRENT YEAR TRUST BUDGET	FORECAST ACTUAL	FORECAST VARIANCE
	£000	£000	£000	£000	£000	£000	£000	£000	£000
INCOME									
NHS Clinical Contract Income	(22,420)	(22,479)	59	(87,468)	(89,393)	1,925	(263,181)	(266,847)	3,877
Other NHS non Clinical	(270)	(423)	153	(771)	(940)	169	(2,317)	(2,095)	62
Other non-NHS Clinical revenue	(97)	(92)	(5)	(389)	(468)	80	(1,167)	(1,647)	481
Private Patient Income	(824)	(859)	35	(3,296)	(3,163)	(132)	(9,781)	(9,619)	(162)
Education & Training Income	(1,884)	(2,068)	184	(7,535)	(7,900)	365	(23,235)	(23,039)	(196)
Research & Development Income	(325)	(124)	(201)	(1,300)	(675)	(626)	(3,863)	(3,736)	(127)
Misc other operating income	(1,754)	(1,008)	(745)	(4,604)	(4,092)	(512)	(14,361)	(11,537)	(581)
TOTAL INCOME	**(27,574)**	**(27,054)**	**(520)**	**(105,364)**	**(106,633)**	**1,269**	**(317,905)**	**(318,521)**	**3,355**
EXPENDITURE									
Medical Pay - Contracted	4,307	3,984	322	16,889	15,738	1,151	50,718	47,950	2,285
Medical Pay - Locum	1	342	(341)	29	1,265	(1,236)	88	3,400	(3,286)
Sub-total Medical Pay	**4,308**	**4,326**	**(19)**	**16,919**	**17,003**	**(85)**	**50,807**	**51,350**	**(1,001)**
Nursing Pay - Contracted	5,172	4,361	811	20,855	17,381	3,474	62,172	54,017	8,047
Nursing Pay - Agency	40	355	(315)	215	1,795	(1,579)	291	4,189	(3,929)
Nursing Pay - Bank	38	555	(516)	58	1,962	(1,905)	130	4,384	(4,306)
Sub-total Nursing Pay	**5,250**	**5,271**	**(20)**	**21,128**	**21,138**	**(10)**	**62,593**	**62,589**	**(188)**
Other Pay - Contracted	3,874	3,350	524	15,386	13,801	1,585	50,079	47,750	2,140
Other Pay - Agency	0	264	(264)	0	690	(690)	0	1,294	(1,294)
Other Pay - Bank	2	342	(340)	6	1,181	(1,175)	16	2,095	(2,080)
Sub-total Other Pay	**3,876**	**3,955**	**(80)**	**15,392**	**15,672**	**(280)**	**50,095**	**51,140**	**(1,234)**
Sub-total Pay	**13,434**	**13,552**	**(119)**	**53,439**	**53,813**	**(374)**	**163,495**	**165,078**	**(2,423)**
Clinical supplies	2,680	3,156	(476)	11,124	11,592	(468)	32,048	34,331	(2,316)
Non-clinical supplies	3,876	3,208	668	13,549	13,925	(376)	40,884	42,294	(3,409)
Drug Costs - Tariff	3,879	3,547	332	14,651	14,644	7	43,032	43,193	(27)
Drug Costs - Exclusions	632	641	(9)	2,517	2,242	275	7,542	7,226	314
Sub-Total Non Pay	**11,068**	**10,552**	**515**	**41,841**	**42,403**	**(562)**	**123,506**	**127,043**	**(5,437)**
TOTAL COSTS	**24,501**	**24,105**	**397**	**95,279**	**96,216**	**(936)**	**287,000**	**292,122**	**(7,860)**
EBITDA	**3,072**	**2,949**	**(123)**	**10,085**	**10,417**	**332**	**30,905**	**26,400**	**(4,506)**
EBITDA %	11.1%	10.9%		9.6%	9.8%		9.7%	7.8%	-1.5%
Depreciation	764	658	105	3,055	2,634	422	9,166	8,236	930
Interest Payable	50	23	27	200	121	79	761	760	1
Interest Receivable	(3)	(8)	6	(10)	(29)	19	(30)	(49)	19
PDC Dividend expense	718	718	(0)	2,873	2,873	(0)	8,618	8,583	35
Profit/Loss on Asset Disposal	0	0	0	0	0	0	0	0	0
SURPLUS / (DEFICIT)	**1,543**	**1,558**	**15**	**3,967**	**4,818**	**852**	**12,390**	**8,869**	**(3,521)**

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

CONFIDENTIAL
Council of Governors Meeting, 16th September 2010

AGENDA ITEM NO.	3.2/Sep/10
PAPER	Performance Report relating to period April - June 2010
AUTHOR	Sherryn Elsworth – Head of Performance Improvement
LEAD	Mark Gammage – Deputy Chief Executive
PURPOSE	The purpose of this report is to update the Council of Governors on the Foundation Trust's performance for the period ending 30th June 2010 (the latest period to have been reported to the Foundation Trust Board) and to highlight performance risks going forward. This paper comprises the summary performance report and the Trust Dashboard which highlights key performance, finance, workforce and quality risks.

Introduction

Chelsea & Westminster's performance is monitored by the Care Quality Commission (CQC) who are responsibility for assuring the quality of healthcare services in England, Monitor who are responsible for regulating Foundation Trusts and commissioners who contract with Chelsea & Westminster for the provision of a range of services at a defined level of quality. There is significant overlap in the metrics tracked by the CQC, Monitor and health service commissioners but despite this fact Chelsea & Westminster still needs to track around 70 metrics to ensure the Trust is adequately tracking the metrics which are of importance to our key stakeholders. Performance against these metrics is reported monthly to the Foundation Trust Board and summarised via a high level Performance Dashboard attached at Appendix 1.

The recent announcement of a policy shift away from national targets and a renewed emphasis on locally defined requirements outlined within service contracts has led to little real change in performance monitoring requirements for Chelsea & Westminster in 2010/11. It is of note that the Care Quality Commission will no longer be publishing ratings (Chelsea & Westminster was previously rated Excellent for both financial management and the quality of our services) but will instead publish benchmarking data against a range of quality indicators.

The performance metrics measured include access targets such as the proportion of patients treated within 18 weeks of referral, the proportion of A&E attendees seen within 4 hours of arrival and Cancer referrals seen within two weeks of referral. Quality metrics include emergency readmissions and the provision of discharge summaries. Efficiency metrics include day case rates and the average number of follow up appointments which a patient may need following a new referral to a hospital consultant.

Overall Performance

Chelsea and Westminster performed well in the first quarter, achieving the required level in the majority of the indicators which are monitored by the Care Quality Commission and Monitor, including access targets such as 18 weeks referral to treatment and the A&E 4 hour wait target and reducing last minute operation cancellations.

Areas of concern

There are some areas where the Trust is not achieving the required performance level and the Foundation Trust management team is seeking the support of colleagues to help improve performance in future months.

<u>Infection Control</u>

The introduction of a much more sensitive test than the one previously used has increased the number of Chelsea and Westminster's reportable Clostridium Difficile (C Diff) cases in 2010/11 with 20 cases reported over the first three months of the year compared to 32 cases for the whole of 2009/10. This is putting the Foundation Trust at risk of incurring financial penalties and losing additional monies gained last year for achieving low C Diff numbers. The Trust is in discussions with commissioners regarding what can be arranged to ensure that the Trust is not penalised for agreeing to the introduction of the new test which is recognised as best practice.

As at the end of June there had been two reportable MRSA cases against an annual target of 3 cases. Both the cases reported were entirely avoidable and occurred as a result of failure to follow Trust infection control policy.

Real Time Patient Feedback

Satisfaction rates as reported by patients using the Patient Experience Tracker (PET) are high however less than half our patients are using the PET so it is unclear whether the results are representative of the patient population. Staff in all areas have been asked to encourage patients to use the PET on their day of discharge to give valuable feedback on their experience in the hospital.

Slot Issues

Over 35% of patients attempting to book an outpatient appointment on line have experienced difficulties booking their appointment against a target of less than 4%. The trust has an action plan to reduce slot issues and is on track to achieve significant improvement to performance in this metric across the summer.

Discharge Summaries

80% of patients' discharge summaries have been sent to their GPs within 24 hours against a target of 100%. Ward teams have been asked to make sure that discharge summaries are completed for all patients within the required time period.

Smoking Advice to Pregnant Women

5.14 % of women have reported that they are smoking at the time of birth against a target of less than 4.13%. The maternity department is reviewing the advice and support offered to help pregnant women avoid smoking.

Daycase rate

The Trust is not achieving the 95% day case target for the range of procedures outlined as suitable to be treated as day cases by the Audit Commission. The Surgery division is investigating which simple procedures are being reported as inpatient stays.

Ethnic Data Quality

The Trust is not ensuring that the ethnic category for all patients is recorded on the patient administration system. All staff are being encouraged to ask patients to confirm their Ethnic status when they attend the hospital.

Action

The Council is asked to note the report. Feedback on the format and content of this report to the Head of Performance Improvement will be welcomed and used to tailor future reports to the requirements of the Council.

Appendix 1

TRUST PERFORMANCE DASHBOARD JUNE 2010

	Indicator Name	Monitored by/ Submission to	Trustwide Target/Threshold	Trustwide Performance YTD	Trustwide Performance in Month	Medicine and Surgery YTD	Medicine and Surgery in Month	Women's, Neonatology, Children's and Young people's, HIV, Sexual Health and Dermatology YTD	Women's, Neonatology, Children's and Young people's, HIV, Sexual Health and Dermatology in Month	Clinical support YTD	Clinical Support in Month
Quality	Incidence of Clostridium difficile	Monitor, CQC, Local Stretch	25.00	20	2	16	2	2	0	2	0
	MRSA Bacteraemia	Monitor, CQC, Local Stretch	0.75	2	0	0	2	0	0	0	0
	Hand Hygiene Compliance	Quality account	90%	82.32%	85.14%	83.13%	84.56%	84.01%	83.63%	79.54%	89.78%
	Hand Hygiene Completion	Quality account	90%	69.49%	71.19%	68.42%	47.37%	66.07%	85.71%	75.00%	93.86%
	Patient falls resulting in moderate or major harm	Quality account	9.0	0	0	0	0	0	0	0	0
	Never Events	Quality account	0.0	0	0	0	0	0	0	0	0
	Emergency Readmissions within 14 days (COPD, heart failure and diabetes)	Contract	5.6%	3.82%	0.00%	3.82%	0.00%	N/A	N/A	N/A	N/A
	Emergency Readmissions within 28 days (COPD, heart failure and diabetes)	Contract	11.0%	5.34%	0.00%	5.34%	0.00%	N/A	N/A	N/A	N/A
	Elective MRSA Screening Ratio	Monitor, Contract	1.00	1.28	1.31	1.16	1.15	1.89	1.88	0.72	1.96
	Non Elective MRSA Screening Ratio	Contract	1.00	To be implemented and monitored from December 2010							
	Mortality (HSMR) (2 months in arrears-just April data) (trajectory)	Quality account	67.18	83.99	83.99	80.33	80.33	187.50	187.50	0.00	0.00
	VTE Assessment	Contract	100%	Audit data collection will begin 20th of July 2010							
	Rapid Access Chest Pain Clinic	CQC, Contract	98.0%	100.00%	100.00%	100.00%	100.00%	N/A	N/A	N/A	N/A
	Quality of Stroke Care	CQC, Contract	80%	75.00%	76.36%	75.00%	76.36%	N/A	N/A	N/A	N/A
	Infant health & Inequalities: % Women known to be smokers	CQC	4.13%	5.41%	6.01%	N/A	N/A	5.41%	6.01%	N/A	N/A
	% Mothers known to initiate breastfeeding	CQC	91.06%	94.75%	94.95%	N/A	N/A	94.75%	94.95%	N/A	N/A
	% Women seen a midwife or obs for assessment by 12+6 (trajectory)	Contract	90%	84.00%	88.00%	N/A	N/A	84.00%	88.00%	N/A	N/A
	Discharge Summaries within 24 hours	Contract	100%	80.13%	79.97%	80.00%	80.17%	80.37%	80.26%	80.06%	77.70%
	Patient Experience Tracker Completion rate	Quality account	80%	34.01%	30.76%	27.66%	19.38%	55.86%	59.59%	16.83%	100.00%
	Patient Experience Tracker overall satisfaction scores	Quality account	90%	89.00%	87.00%	90.00%	87.00%	88.00%	87.00%	96.00%	87.00%
	Complaints and concerns for admissions and appointments	Quality account	54	151	55	71	32	43	16	17	3
	Formal complaints responded in 25 working days	Quality account	90%	83.33%	85.11%	81.82%	84.21%	66.67%	81.25%	100.00%	100.00%
	P.E.A.T. scores	Quality account	Excellent: Food,	Audit data collection will begin 20th of July 2010							
	Breach of Same Sex Accommodation	Contract	0	0	0	0	0	0	0	0	0
Finance	Income variance	Internal	£51,238,071	£ 1,788,891	£ 197,603	£177,467	-£336,615	£577,019	£456,993	-£24,975	£16,107
	Pay variance	Internal	£26,244,611	-£ 255,461	-£ 208,509	-£258,495	-£156,601	-£363,291	-£368,095	-£234,574	-£79,078
	Non Pay variance	Internal	£20,640,420	-£ 1,077,526	-£ 146,276	£113,430	£435,415	£73,335	-£44,363	£98,092	-£27,355
	EBITDA	Internal	£30,905,000	£ 455,904	-£ 157,182	£32,402	-£57,801	£287,063	£44,535	-£161,457	-£90,326
	Clinical Activity Value	Contract	£42,769,200	£ 1,070,803	-£ 401,502	£764,289	£52,439	£833,466	£239,483	£13,085	-£27,669
	CIP Identified	Internal	100%|£22552k	-23%|-£1,133k	-15%|-£254k	-56%|-£663k	-36%|-£180k	1%|£22k	12%|£70k	-43%|£481k	-38%|-£140k
	CIP Delivered	Internal	100%|£22552k	-34%|-£1,668k	2%|£26k	-56%|-£663k	-31%|-£157k	-20%|-£335k	-60%|-£335k	-43%|-£474k	-36%|-£133k
	Value of Error Corrected after Month End	Internal	0%	Indicator methodology to be defined							
	Follow Up Value above Plan	Contract	0	Exclusions agreed end Q1, monitoring will commence Q2							
	Emergency Activity above Threshold	Contract	£0	Further analysis required, monitoring to commence Q2							
	Unfunded Low Priority Procedures	Contract	50%	Exclusions to be agreed prior to monitoring							
	Unfunded Consultant to Consultant Referrals	Contract	0	Exclusions agreed end Q1, monitoring will commence Q2							
	Encountering	Contract	100%	96.23%	96.39%	94.54%	94.47%	97.21%	97.47%	97.45%	98.42%
Activity	Regular Day Attender	Contract	1,687	2,224	783	500	186	1,724	597	0	0
	Same day procedure	Contract	4,889	5,004	1,706	2,142	749	1,545	530	1,317	427
	Elective Against Plan	Contract	1,770	1,857	629	1,144	374	690	243	23	12
	Non-Elective Against Plan	Contract	9,545	9,853	3,335	4,089	1,346	5,714	1,966	50	23
	Outpatient New	Contract	39,246	41,235	14,715	10,736	3,917	27,411	9,676	3,004	1,090
	Outpatient Follow Up	Contract	55,325	56,659	19,877	27,057	9,463	26,252	9,287	1,365	424
Workforce	Agency|Bank usage	Internal	TBC	32%|68%	33%|67%	27%|73%	27%|73%	34%|68%	35%|65%	37%|63%	38%|62%
	Turnover Rate	Internal	14%	12.4%	12.4%	9.1%	9.1%	9.6%	9.6%	14.6%	14.6%
	Vacancy Rate	Internal	10%	14.5%	14.1%	15.1%	16.7%	17.4%	15.4%	10.4%	11.3%
	Sickness Rate (MAY)	Internal	3.60%	3.0%	3.2%	2.7%	2.7%	3.9%	3.9%	2.1%	2.6%
	Shifts/Sessions covered by Agency(WTE)	Internal	TBC	122.23	116.32	39.37	38.93	38.98	40.60	36.59	36.74
Efficiency	Length of Stay	Internal	TBC	3.08	2.97	4.77	4.54	1.86	1.87	7.29	6.17
	New:Follow Up Ratio	Contract	TBC	1.37	1.35	2.52	2.42	0.96	0.96	0.45	0.39
	Daycase rate	Internal	TBC	72.93%	73.06%	65.19%	66.70%	69.13%	68.56%	98.28%	97.27%
	Basket Daycase Rate (exclusons to be applied from Q2)	Contract	95%	76.04%	77.64%	78.86%	79.68%	72.01%	75.00%	N/A	N/A
	Delayed Transfers of Care	CQC	3.5%	0.89%	0.45%	1.25%	0.68%	0.00%	0.00%	0.00%	0.00%
	Non birth related admissions Ratio	Contract	0.7	0.57	0.76	N/A	N/A	0.57	0.76	N/A	N/A
Access	18 Weeks Data Completeness - Admitted patients -	CQC, Contract	90% - 110%	98.86%	111.11%	101.06%	99.38%	104.56%	111.11%	42.86%	34.29%
	18 Weeks Data Completeness - Non- Admitted patients -	CQC, Contract	90% - 110%	98.17%	95.81%	91.02%	88.46%	99.97%	95.81%	N/A	N/A
	18 weeks Admitted performance	CQC, Contract	90%	94.10%	94.21%	93.15%	92.82%	95.00%	95.68%	100.00%	100.00%
	18 weeks Non-Admitted performance	CQC, Contract	95%	99.29%	99.15%	97.65%	97.67%	99.75%	99.58%	N/A	N/A
	Percentage of treatment functions achieving the 90% standard for admitted	CQC, Contract	TBC	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	RTT Outcome Compliance	Internal	100%	89.67%	90.31%	90.92%	90.64%	88.29%	90.25%	61.26%	65.41%
	CWT: 31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	Monitor, CQC	96%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	N/A	N/A
	31-Day Wait For Second Or Subsequent Treatment: Surgery	Monitor, CQC	94%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	N/A	N/A
	31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	Monitor, CQC	98%	100.00%	100.00%	100.00%	100.00%	N/A	N/A	N/A	N/A
	31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	Monitor, CQC	94%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	CWT: 62-Day (Urgent GP Referral To Treatment) Wait For First Treatment	Monitor, CQC	85%	95.88%	94.29%	96.15%	86.67%	95.56%	100.00%	N/A	N/A
	62-Day Wait For First Treatment From Consultant Screening Service Referral	Monitor, CQC	90%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	62 Consultant upgrade	Monitor, CQC	85%	100.00%	N/A	100.00%	N/A	100.00%	N/A	N/A	N/A
	Cancer urgent referral to first outpatient appointment waiting times: All 2WW	Monitor, CQC	93%	93.54%	91.14%	95.63%	94.20%	91.89%	88.76%	N/A	N/A
	2WW for Symptomatic Breast Patients	Monitor, CQC	93%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Inpatient 26 Weeks	Internal	0.03%	0.02%	0.06%	0.04%	0.13%	0.00%	0.00%	0.00%	0.00%
	Outpatient 13 Weeks	Internal	0.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Diagnostic <= 6 Weeks	Contract	100%	99.79%	99.96%	95.24%	97.83%	97.40%	100.00%	99.97%	100.00%
	GUM Access within 48 hours	CQC	98%	100.00%	100.00%	N/A	N/A	100.00%	100.00%	N/A	N/A
	All Referrals	Internal	TBC	45,766	9,589	21,870	4,523	23,896	5,066	N/A	N/A
	Slot Issues per DBS booking (trajectory)	Contract	<=4%	33.99%	37.97%	N/A	N/A	N/A	N/A	N/A	N/A
	Cancelled operations by the hospital for non-clinical reasons on the day of or after admission	CQC, Contract	<=0.8%	0.42%	0.53%	0.64%	0.50%	0.35%	0.88%	0.00%	0.00%
	Cancelled operations by the hospital for non-clinical reasons on the day of or after admission, who were not treated within 28 days.		<=5%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	A&E 4 Hour Target	Monitor, CQC, Contract	98%	99.10%	99.30%	99.10%	99.30%	N/A	N/A	N/A	N/A
	A&E Minors 4 Hour Target	Contract	100%	99.67%	99.59%	99.67%	99.59%	N/A	N/A	N/A	N/A
Other	Ethnic Data Quality	CQC	95%	93.97%	94.28%	97.05%	97.94%	90.72%	90.54%	93.82%	93.85%

NB: Where there are multiple targets (e.g. MRSA/C Diff CQC/local stretch) the RAG rating is against the most challenging targe

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 16 September 2010

AGENDA ITEM NO.	3.3/Sep/10
PAPER	Patient Safety Questions (FTGA) – tabled*
AUTHOR	Cathy Mooney, Director of Governance and Corporate Affairs
LEAD	Cathy Mooney, Director of Governance and Corporate Affairs
SUMMARY	You will have received a hard copy of the FTGA publication titled: 'Questions are the Answer!' We have prepared answers which incorporate comments received from the Quality Sub-Committee. If you have any queries re the answers provided or wish to discuss further please contact Cathy Mooney or Vida Djelic.
DECISION/ ACTION	To note.

Questions are the Answer!

Seven questions foundation trust governors can ask about patient safety in their organisations

Q1 Does everyone understand the importance of patient safety?

Why is it important? A clear and explicit view of patient safety and reducing harm to patients is fundamental to setting standards and goals. Patient safety is everyone's responsibility and everyone needs to understand what it means for them.

What does good look like? Patient safety is a top organisational priority. The trust board has a clear strategy for patient safety that sets specific, measurable and challenging goals for improving the safety of patient care and reducing patient harm each year. A public commitment to this is made. There are named executive and non-executive board members responsible for patient safety and it is made clear that everyone from board members through to frontline staff are involved and have a part to play.

You might want to ask

> Question 1.1: Has the board made a public commitment to ensuring patient safety is a top priority?

Answer: Not as such but Quality (safety, effectiveness and patient experience) is the first item on the Board agenda after the standard items. Patient safety is one of the Trusts priorities and there are a number of safety specific objectives as part of the overall Trust objectives e.g. reducing deep vein thrombosis, reducing MRSA. These are disseminated through induction of all new staff, continued training for safety, and investigation and learning from safety incidents. The quality committee takes an overview and each individual directorate will develop a plan to improve patient safety as part of the overall quality improvement plan.

> Question 1.2: What are the trust's specific goals for reducing harm to patients?

Answer: These are part of the overall Trust objectives and are as follows:
1. To reduce hospital acquired preventable venous thromboembolism (VTE) by 20%

2. To reduce the incidence of falls resulting in moderate or major harm by at least 25% in 2010/11

3. No elective patient to be infected with MRSA bacteraemia while in the hospital.

4. Reduce in-hospital cardiac arrest and mortality through early recognition and treatment of the deteriorating patient

5. To meet agreed targets based on National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations for emergency surgery

6. To reduce the Hospital Standardised Mortality Ratio (HSMR) by 5%

7. To be at or below the national average of patients with an indwelling urinary catheter and to reduce the number of urinary catheter days, excluding patients who need a lifelong urinary catheter.

> Question 1.3: Does the board own, monitor and publish these goals?

Answer: Yes. The Board agreed these objectives. Monitoring is done via the assurance Committee every quarter and via a report on progress with objectives made directly to the Board also every quarter. Progress against safety indicators is monitored by the Board every month.

Q2 Does the trust really have an open and fair culture?

Why is it important? Staff are less likely to report incidents or raise safety concerns if they are punished or blamed. Most incidents are as a consequence of weaknesses in the system, which then affects the performance of the individuals within that system. A culture of blame can drive reporting underground and prevent us from learning what makes things safer.

What does good look like? The chair and chief executive make a clear, public commitment to staff that the organisation fully supports an open and fair culture. When things go wrong, staff feel able to be open, they are treated fairly and failures in the system are identified and improved, rather than seeking to blame specific individuals at the 'sharp end'. Regular board safety walkrounds provide an opportunity to talk to frontline staff, patients and their families about their experiences and opportunities to improve safety.

You might want to ask

> Question 2.1: What commitment has been made by the board to an 'open and fair culture'? Do managers use the NPSA's Incident Decision Tree when something has gone wrong?

Answer: The board actively supports open communication between organisations, teams, staff and patients and/or carers/families. This is supported within Trust guidance, which advises that when things go wrong it is important that relevant parties are kept fully informed and offered support throughout the process. Openness also has benefits for staff. This includes satisfaction that communication with patients and/or carers has been handled in the most appropriate way. Additional information relating to communication with patients and relatives can be found in the Being Open Guidance, published on the Trust intranet.

The Incident Decision Tree is regularly used as a tool to support senior staff to determine a fair and consistent course of action toward staff involved in incidents. The tool encourages investigation teams to move away from asking "Who was to blame?" to asking "Why did the individual act in this way?" when things go wrong.

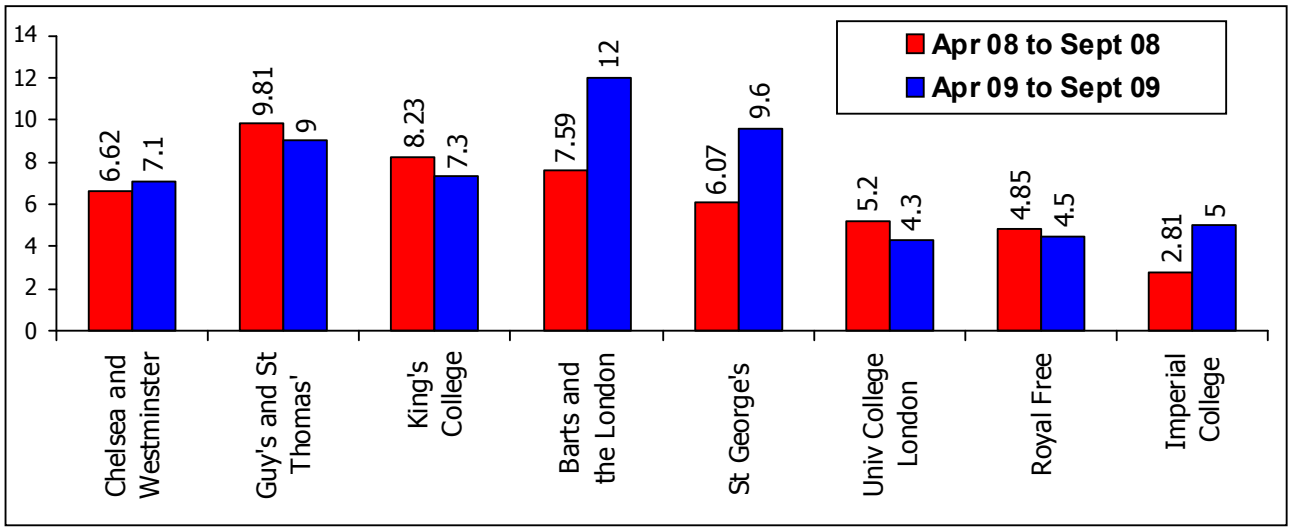
> Question 2.2: How many incidents that have affected patient safety were reported by staff last year? How does this compare to numbers reported by similar organisations?

Answer: A total of 5,829 incidents were reported last year, April 2009 to March 2010. 4,623 related to patient safety incidents (clinical incidents), and 1,206 related to general Health and Safety (non-clinical) incidents.

With specific reference to patient safety incidents, the graph below shows the reporting rate per 100 admissions, comparing the Chelsea and Westminster Hospital's patient safety incident reporting rate with other Acute Teaching Trusts in the London Strategic Health Authority, based on incidents occurring between April 2008 and September 2008,

and also April 2009 and September 2009. The reporting rate per 100 admissions at the Chelsea and Westminster Hospital was 7.1 in 2009/10, compared with an average of 5.8 reporting rate at similar Trusts.

Chart 7.4: Reporting rate per 100 admissions: Comparing Acute Teaching Trusts in NHS London



It is most often the case that those organisations which report more have a stronger learning culture where patient safety is a high priority – so resulting in better and more established reporting amongst all staff.

Q3 Does the trust actively encourage reporting of incidents?

Why is it important? Organisations that report more incidents usually have a better and more effective safety culture. We can not learn and improve if we do not know what the problems are. It is important to know what happened and why it happened.

What does good look like? The trust encourages staff to report things that went wrong or that might go wrong. The board uses national comparative data from the National Patient Safety Agency to see where the trust features in terms of numbers reported and levels of harm reported.

You might want to ask

> Question 3.1: What steps have been taken to encourage front line staff to actively report incidents that affected patient safety?

Answer: We have a proactive approach to risk and incident identification, assessment and effective action planning. This can be seen in the increased number of yellow incidents that are reported and reviewed via the formal investigation process and also the number of 'near miss' incidents reported. We use comparative data from the National Patient Safety Agency to see where the trust features in terms of numbers of reported and levels of harm reported.

There is one incident reporting system for everything; rather than having a separate system for different types of event. Reports, newsletters and general feedback is regularly provided to teams at all levels across the organisation. This information is also published on the trust intranet.

> Question 3.2: How do you measure the success of this process?

Answer: Success and effectiveness of the incident reporting process is measured through a range of key performance indicators, which include the following:

- Quarterly Quality Reports to each Division
- Weekly and monthly reports to teams and service leads
- Quarterly Risk Management Reports detailing trend analysis, summary of red and orange incidents and Trust wide learning to the Risk Management Committee and the Health and Safety Committee. All incidents are graded according to their outcome and the consequence and likelihood of them happening again, using a risk matrix. This then grades an incident as yellow, green, orange or red. Orange and red incidents are investigated thoroughly using root cause analysis. This is a process using a range of tools which seeks to understand all the factors involved in an incident and how an incident can be prevented from happening again.
- Annual Risk Management Report to the Board
- Quarterly review of any outstanding actions relating to incident investigations (the Incident Review Register) at the Risk Management Committee

Also, as noted above, the Trust sends monthly data relating to incidents reported to the National Patient Safety Agency via the National Reporting Learning System. Trusts that report incidents regularly suggest a stronger organisational culture of safety. We take all incidents seriously and link reporting with learning.

Q4 Do we get the right information?

Why is it important? Learning from all sources of data together provides an organisation with a true reflection of where things are going wrong and what is needed to prevent minor incidents from becoming serious incidents.

What does good look like? The trust draws from many sources including; reported incident themes and rates, clinical risks, complaints, claims, PALS, unexpected deaths, Hospital Standardised Mortality Ratios and issues highlighted from case note reviews. The board scrutinises these data effectively to make sure that the organisation learns from them, takes action and monitors the action. The board uses patient and staff stories to put a 'human face' on the numbers and actively seeks accounts of patient experience wherever possible. The board is kept informed of serious and ongoing issues and recognises the links between staffing and quality outcomes and patient safety.

You might want to ask

> Question 4.1: How does the board assure itself that the organisation learns from all the above sources?

Answer: Sources of data described above includes
a) Incident themes and rates, clinical risks, complaints, claims and PALS. There are reported to the Quality Committee and then to the Assurance Committee every quarter and to the Board annually. Reports contain sections on learning.
b) Unexpected deaths – monthly deaths are circulated to clinicians for checking coding and to allow follow up. Deaths are also discussed at mortality and morbidity meetings and forms are used to capture information which is then included in the quarterly quality reports to each division.

Changes that have been made as a result of incident investigations and learning include that consultants within obstetrics are allocated to all local forums to ensure a consultant led service. Also, in February 2010 new observation charts and communication sheets were launched in all Adult clinical wards. The charts enable the recording of all relevant

early warning scoring data on one sheet, reducing the risk for loss of data on multiple charts and aimed at improving the calculation of the early warning score. With improved data collection and appropriate scoring, there is an expectation of increased escalation of appropriately high scoring patients.

Other initiatives include the purchase of new intravenous medication and fluid pumps to improve safety in use by standardisation; and we have published a patient information leaflet on DVT and PE and a pocket guide for staff which includes guidance on assessing risk factors for VTE and treatment to prevent VTE in at-risk patients. We have designed an electronic VTE risk assessment for use with adult inpatients which highlights what preventative treatment may be required, supported by an electronic prescribing alert which appears if an at-risk patient has not been prescribed preventative anticoagulant drugs.

> Question 4.2: What is the Hospital Standardised Mortality Ratio (HSMR) for the trust? Has work taken place to identify what can be done to decrease the HSMR in the coming 12 months?

Answer:
HSMR compares a Trust's number of actual deaths (mortality) with expected deaths. It is a calculation that takes into account a number of different factors that may affect mortality rates such as age, sex, diagnosis, length of stay and whether an admission was elective or emergency. The factors are regularly reviewed and recalculated at intervals to take into account improvements in healthcare generally, for example to reflect the fact that people are on average living longer. An HSMR of 100 means that the number of deaths is in line with expectations, an HSMR above 100 represents a higher mortality (death) rate, and an HSMR below 100 represents a lower mortality rate.

The HSMR for Chelsea and Westminster is 75.7 and the current comparison with our peers based on the latest recalculation is below:

Peer (My current group)	Deaths	%	Expected	%	RR	Low	High
ALL	5810	2.90%	7925.3	3.90%	73.3	71.4	75.2
Barts and the London NHS Trust	1045	3.20%	1413.2	4.30%	73.9	69.5	78.6
Chelsea and Westminster Hospital NHS Foundation Trust	428	3.00%	565.3	3.90%	75.7	68.7	83.2
Guys and St Thomas NHS Foundation Trust	1030	2.70%	1302.4	3.40%	79.1	74.3	84.1
Imperial College Healthcare NHS Trust	1593	2.80%	2332.5	4.20%	68.3	65	71.7
Kings College Hospital NHS Foundation Trust	1004	3.80%	1179.9	4.50%	85.1	79.9	90.5
University College London Hospitals NHS Foundation Trust	710	2.00%	1132	3.20%	62.7	58.2	67.5

As noted in the objectives above, reducing the HSMR further is a trust objective.

> Question 4.3: How do we know that there are sufficient nursing staff on duty at all times? How is this monitored and is there a tool used to calculate this?

Answer: The rotas for the clinical areas are carefully planned by the ward sister/charge nurse and checked by the matron, to ensure that the correct number and skill mix of nursing staff are on each shift. If there are vacancies or sickness then an appropriate bank or agency nurse is booked for the shift. The trust is currently introducing a new

model of measuring the dependency of patients against the numbers and skill mix of staff.

Q5 Are we always open when things go wrong?

Why is it important? Communicating effectively with patients and their carers is a crucial part of dealing with incidents or problems in treatment. Saying sorry, providing an explanation and keeping them informed will help patients and their families to cope when things have gone wrong. It is also vital to provide staff with support to cope with the incident and to help them communicate well.

What does good look like? Those who may need to be involved in talking with patients and their family and carers when things have gone wrong are appropriately trained and fully supported in this process. Patients and their families are involved in learning from patient safety incidents.

You might want to ask

> Question 5.1: Has the Trust implemented a Being open policy and appointed Senior Clinical Counsellors to support colleagues in Being open?

Answer: The Trust has implemented a Being Open Policy, but has not appointed Senior Clinical Counsellors to support colleagues in Being Open. A number of sources of help for those (staff or patients) involved in an adverse or traumatic event are noted within the Trust's Being Open Policy; these are as follows:

Internal	
Line Manager	Support for staff involved in adverse event. On a 1:1 basis for arranging debriefs etc.
Chaplaincy Team	The Trust Chaplaincy is available to provide confidential spiritual and personal support to all staff and patients from all backgrounds and faiths.
Complaints Team	Advise and give preparatory support to staff in respect of writing written statements in response to complaints.
Head of Legal Services	Provide support and advice to staff involved in a claim or in the event of being called as a witness to any court proceedings including inquests and ad-hoc legal matters. Note: In the case where a staff member is claiming against the Trust, the legal services department is prevented from providing advice to staff. Staff can however contact Occupational Health who will signpost them to an appropriate Support Agent.
Occupational Health	Advise on coping strategies for staff

	experiencing difficulties at work. The Occupational Health Department is able to advise on coping strategies for staff experiencing signs of anxiety or stress as a direct consequence of the event in question. Occupational Health involvement may be appropriate when staff are involved in particularly stressful or traumatic clinical incidents such as complaints, major incidents or accidents, violent patient incidents or a court appearance as a Trust representative. This interaction will be on a confidential basis and may include referral to Staff Counselling Services, the employee's General Practitioner (GP) or other appropriate agencies. Occupational Health can be contacted on ext 58330
Counselling Service	The Staff Counselling Service is free for staff employed by Chelsea & Westminster Hospital NHS Foundation Trust and functions independently of Occupational Health. Staff may refer themselves to the Counselling service by ringing 0800 269 616 (24 hours a day, 7 days per week).
Head of Clinical Governance or Risk Managers	The Head of Clinical Governance or Risk Managers can advise staff and give preparatory support in respect of implementing the various risk management processes, such as reporting and investigating incidents, providing advice for staff regarding providing written statements for investigations, and carrying out internal investigations.
Human Resources Managers	Support managers in identifying staff support needs and providing appropriate sources of support once identified.
Head of Security	Advice and Support for staff following violence or security incidents at work. Will refer to NHS Security Management Services where necessary and support staff through any resulting prosecution against an aggressor.
Child Protection Leads	Cases involving child protection issues can be particularly distressing and complex in nature. The Child Protection Nurse can provide general support in these instances and can provide preparatory support for staff who may be required to attend case conferences and / or associated meetings.
PALS Service	Arrangement of translation services.

	Contact number for external organisations who can provide support to those involved in an adverse event.
Staff Side / Trade Union Representative	Advice and support staff. Working closely with HR and line management, trade union representatives will be able to provide an insight into the processes associated with internal performance management issues. Trade Union representatives will also be able to guide the member toward union legal advice and assistance should this be necessary.
External	
General Practitioner	A resource for the support of staff and patients / carers. Staff would need to self refer. Consent would be required from a patient/carers if referrals for support is indicated. Patients and carers may also self refer.
Professional bodies	Advise staff on being a witness / providing statements.
British Association for Counselling and Psychotherapy www.bacup.co.uk	The "Seeking a Therapist" section of the website gives list of qualified counsellors and therapists by area.

> Question 5.2: How do you monitor implementation of Being open?

Answer: Open communication with patients, families, and other healthcare organisations and teams is audited as part of an annual review of the investigation files relating to orange and red incidents. This annual review includes an audit of the documentation relating to 'being open' discussions, as indicated on incident forms and also on incident review investigation checklists.

Action taken by managers where staff members experienced difficulties associated with an incident is managed and monitored within each division's governance arrangements, and information filed within staff personal files held within departments, by Occupational Health and/or the Human Resources Department.

Q6 Does the trust learn from patient safety incidents?

Answer: Yes; reporting patient safety incidents is essential, but it is only part of the process of improving safety. Equally important is the routine practice of teams looking at the underlying causes of incidents and learning how to prevent them from happening again.

Teams and operational managers review aggregated reports detailing incidents submitted that refer to their area of responsibility. Managers communicate with colleagues, for example at ward or departmental meetings, or via one of the corporate committees such as the Health & Safety Committee, or the Risk Management

Committee, and agree the level of requirements needed to resolve issues and introduce preventive measures against recurrence of the reported or similar problems.

Where actions are required to prevent a recurrence of an adverse event, near miss or concern, an action plan is prepared and followed through, detailing:

- actions to be taken
- member of staff responsible for each specific action
- timescale for action to be implemented
- deadlines for completion

Details of actions are actively monitored to ensure that lessons learned are implemented and communicated organisationally and at local clinical effectiveness, ward, and departmental levels, in accordance with the timescales stated for each action. Once actions have been implemented, evidence of completion is submitted in order to provide feedback to teams with regard to the learning or changes in patient care that have been made as a result of active reporting.

Why is it important? A robust methodology should be in lace to ensure incidents are thoroughly investigated so that all contributing factors and root causes are identified and any recommendations are implemented successfully. Providing feedback will enhance reporting and learning. There must be clear, rapid, and useful feedback on lessons learned and actions taken.

What does good look like? Staff are trained in investigation techniques such as Root Cause Analysis. Lessons learned and recommendations are implemented where relevant throughout the organisation and not just where an incident occurred. Implementation is planned and carefully monitored.

You might want to ask

> Question 6.1: What issues are raised from patient feedback/PALS/Staff survey that highlight possible patient safety concerns? How are these issues acted upon? What changes have been made to improve patient safety as a direct result of receiving this feedback?

Answer: The trust has a culture of ongoing learning from incidents and complaints. An excellent example of this is the way in which the trust has approached the issue of patient falls. It was highlighted from complaints and incidents data that there are a high number of patient falls in the trust. A falls prevention group has been set up, chaired by the Director of Nursing to implement a robust action plan to reduce falls over the coming year.
The Trust also receives complaints in relation to communication and staff attitudes. The Director of Nursing is currently leading on the development of a Patient Experience Strategy which will address these areas of concern.

If there are enough responses for a particular department (minimum of 10) the staff survey report is divided into departments and each department can take on board the specific issues highlighted regarding patient safety by their teams. This level of accountability is essential to drive improvements at a local level. Each division will prepare a higher level improvement plan in response to the staff survey, including patient safety concerns.

> Question 6.2: What process is used to ensure that recommendations are fully implemented in the long term?

Answer: The Director of Nursing meets regularly with each division to discuss their responses and action plans in relation to incidents and complaints. The Trust also produces an annual complaints report which reviews the numbers and types of complaints year on year, and highlights the lessons learned and actions taken.

Q7 Does the trust actively implement national guidance and safety alerts?

Why is it important? It is vital to learn lessons from outside the organisation as well as from local information. National analysis of incidents highlights safety risks and issues that may not be readily detectable from analysis at trust level.

What does good look like? The organisation has an efficient and effective response to all national guidance and alerts. There is robust monitoring of implementation and the actions required quickly become embedded in the organisation.

You might want to ask

> Question 7.1: How does the board assure itself that national patient safety guidance and safety alerts are embedded in the work of the organisation for all staff?

Answer: The Trust has a system to respond to guidance issued by the National Patient Safety Agency (NPSA) and also the National Institute for Health and Clinical Excellence (NICE). National guidance and safety alerts, along with supporting material, including any recommendations specified within the guidance or alert is sent to nominated leads. Nominated leads report feedback relating to implementation of national guidance to one of two responsible committees; the Trust Executive Quality Committee (responsible for the review of implementation of NICE guidance) or the Risk Management Committee (responsible for the review of implementation of NPSA guidance). There is robust monitoring of implementation in order that the actions required are quickly embedded throughout the organisation.