Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting

Hospital Boardroom
Chair: Prof. Chris Edwards
Date: 14 February 2008
Time: 4:30pm

Agenda

1. GENERAL BUSINESS	**4.30pm**
1.1 Apologies for Absence	**CE**
1.2 Declaration of Interests	**CE**
1.3 Minutes of Previous Meeting held on 8 November 2007 (attached)	**CE**
1.4 Matters Arising (attached)	**CE**
1.5 Chairman's Report (attached)	**CE**
1.6 Chief Executive's Report (attached)	**HL**
1.7 Register of Interests (attached)	**CE**
2. ITEMS FOR DISCUSSION/DECISION/APPROVAL	**4:45pm**
2.1 Business Planning (attached)	**LB**
2.2 Changes to Constitution (attached)	**CE**
2.3 Healthcare Commission Standards for Better Health Commentary (attached)	**CE**
2.4 Membership: Recruitment, Engagement and Sub Committee Highlights (attached)	**CM**
2.5 Open Day (attached)	**CE**
2.6 Healthcare for London: Consulting the Capital (oral)	**CE**
2.7 Chelsea and Westminster Health Charity London Duathlon (oral)	**FF**
3. ITEMS FOR INFORMATION	**5:30**
3.1 Finance Report – Month 9 (attached)	**LB**
3.2 Performance Report – Month 9 (attached)	**LB**
4. ANY OTHER BUSINESS	
5. DATE OF THE NEXT MEETING	
8th May 2008	

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 14th February 2008

AGENDA ITEM NO.	1.3/Feb/08
PAPER	Minutes of the Previous Meeting held 8th November 2007
AUTHOR	Julie Cooper, Foundation Trust Secretary/Head of Corporate Governance
LEAD	Prof. Chris Edwards, Chairman
EXECUTIVE SUMMARY	This paper outlines key issues for the attention of the Members Council.
DECISION/ ACTION	1. To agree the minutes as a correct record. 2. The chairman to sign the minutes.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Date…… **Signed……**

DRAFT
Members' Council Meeting Minutes, 8 November 2007

Present:

[Quorum: 12 Council Members with a minimum of 4 public/patient, 1 Staff and 2 appointed]

Council Members:
Chris Edwards (CE), Chairman
Julie Cooper (JC), Foundation Trust Company Secretary

Brian Gazzard (BG), Staff – Medical & Dental
Duncan Macrae, Appointed - Royal Brompton & Harefield NHS Trust
Christine Blewett (CB), Public – Hammersmith & Fulham 2
Nicky Browne (NBr), Royal Marsden NHS Foundation Trust
Mervyn Maze (MM), Imperial College
Frances Taylor (FT), Appointed - Royal Borough of Kensington & Chelsea
Catherine Longworth (CL), Westminster PCT
Valerie Arends (VA), Public – Kensington and Chelsea
Lionel Foulkes (LF), Public – Wandsworth 2
Maria-Elena Arana (MA), Patient
Vivian Wood (VW), Hammersmith and Fulham PCT
Peter Molyneux (PM), Appointed, Kensington & Chelsea PCT
Jane King (JK), Patient
Alison Delamare (AD), Staff – Contracted
Cathy James (CJ), Staff – A&C
Martin Rowell (MR), Patient
Ann-Mills Duggan (AMD), Public – Westminster Area 1
Nathan Billing (NB), Staff-Allied Health Professionals
Chris Birch (CB), Patient

In Attendance:
Heather Lawrence (HL), Chief Executive
Cathy Mooney (CM), Director of Governance and Corporate Affairs
Maxine Foster (MFo), Director of Human Resources
Charles Wilson (CW), Non-Executive Director
Amit Khutti (AKh), Director of Strategy and Service Performance
Lorraine Bewes, Director of Finance
Hannah Coffey, Director of Operations
Heather Bygraves (HB), Deloitte and Touche – for item 2.2
Berge Azadian (BA), Director of Infection Prevention and Control –item 2.9

1. GENERAL BUSINESS

1.1 Apologies for Absence

Apologies for absence were received from:

Jim Smith (JS), Patient
Prof Salman Rawaf (SR), Appointed, Wandsworth PCT
Sandra Jowett (SJ), Appointed – Thames Valley University
Michael Henry (MH), Patient

1.2 Declaration of Interests

None

1.3 Minutes of the Previous Meeting Held 20 September 2007

The minutes were approved with the following amendment:
Nicki Brown was in attendance.

1.4 Matters arising

Patientline (1.4/Sept/07)
HL said that Patientline has reduced the charge for outgoing calls from 26p to 10p per minute and that incoming calls will continue to be charged at 39p off – peak and 49p peak. Incoming call charges are ruled by Oftel and thus Patientline has no control over this. She invited the Members' Council Communication Sub Committee to play a role in any future negotiations over call charges. LF asked about the possibility of buying Patientline, which had been raised as an option at an earlier meeting. HL said as the call charges have come down there was no rationale for such a purchase other than we would have our own switchboard.

Patient and Public Involvement in Research (1.4/Sept/07)
Copies of the list of current research projects was provided at the meeting.

Minutes from the Membership Development and Communications Sub Committee (2.3/Sept/07)
1. The possibility of holding membership surgeries is on the agenda for discussion.
2. Leaflets are being provided in the St. Stephens Centre.
3. Council Members are distributing leaflets in GP surgeries.
4. A paper on how to increase membership is on the agenda.

Membership Report (2.4/Sept/07)
Membership leaflets were made available to Council Members for distribution within their respective constituencies.

Members' Council Future Agenda Items (2.6/Sept/07)
JC reported that no suggestions for agenda items had yet been made. CE said that he hoped as time went on Council Members would feel more inclined to offer suggestions.

Performance Report (3.2/Sept/07)
A glossary of terms is now attached to both the finance and performance report.

1.5 Chairman's Report

CE said he was delighted with the Trust's double excellent rating from the Healthcare Commission. It was good news for the Trust and good for morale. The trust will be making a one-off payment of £100 to all staff as a sign of appreciation and congratulations to everyone for a job well done.

CE noted the good turnout at the AGM.

CE said that a great deal of activity was happening around the future of healthcare delivery in London. He invited HL to talk to this item. She said that an update on the upcoming consultation for Healthcare for London was being circulated. The consultation will commence on the 30th November and run for 14 weeks until 7 March. The London Commissioning Group is looking for a specific response from the Members' Council. Thirty-one local PCTs have come together to provide a response, but individual local input will be equally important. HL invited PM to comment. PM said the consultation was about principles not just buildings. We need to think what these principles will mean in terms of healthcare delivery in London. The PCT will be holding events throughout the borough to seek the views of individuals and he encouraged the Council to get involved. CE thanked PM for his input and said that the pitfalls in the past have been around translation of these principles into practice.

CE said that the issue of infection control would be addressed under agenda item 2.9.

CE drew the Council's attention to paediatrics. PCTs in North West London are taking forward a review looking to concentrate specialist paediatric services as there are concerns over the fragmentation of the current service. CL said that it would be useful to have an overview from the Trust on where things are at present. CE said the review is both a threat and an opportunity, as paediatrics represents £7-£10M in revenue per annum. Losing paediatrics would also have a knock-on effect on the support being provided to the Royal Brompton Hospital as well as to anaesthetics. The figures suggest that 80% of paediatric activity is centred on the Fulham Road. The Boyd report suggested that all children's services move to the new site at Paddington, and as these plans have been terminated, there may be some suggestion that paediatric services move to St Marys. We are all aware of the implications such a potential move would have and he asked the Members' Council to start thinking about their response and the course of action we should be taking. FT and LF both raised the issue of accessibility and transport with regards the service moving to St Marys. CL said the decision needs to be clinically based. CE said that HL and her team have produced a map to look at where children patients come from. BG reiterated what PM had said, which was this should be a patient-led process. PM said he was pleased to hear the types of comments being made and he stressed that we must get our heads around the clinical need and how we can use the clinical evidence to guide discussions. PM said that the Members' Council should have a good understanding of the potential impact to patients and he appreciates that it is not in the interest of the PCT to do anything that might de-stabilise Chelsea and Westminster hospital. We want specialist paediatrics here at Chelsea and Westminster-but this is a personal view. Transport is not an argument. There are already some excellent specialist services being provided at Chelsea and Westminster, but there are some gaps and these need to be addressed. VW said she felt she has somewhat of a conflict of interest, but she is glad to hear people's views. NBr asked if there had been a test case for a loss of service for another FT. HL said there has not.

CE said that the Chelsea and Westminster Health Charity were sponsoring a duathlon and he encouraged the Members' Council to get involved as well as to help promote the event amongst the membership.

2. ITEMS FOR DECISION/APPROVAL

2.1 Business Planning

LB said the Members' Council and the Membership have a key role in expressing news on the annual plan and in adding a community perspective. The paper is being brought to the Members' Council much earlier this year with the view for the Council to play an even greater role. We will be looking at aim and values and making sure that directorate-specific plans are in line with these. We took stock of the process last year and we want to build on it this year. We intend to have engagement with our host PCT and wide staff involvement. The purpose of the paper is to ask how the Members' Council wants to be involved. LB drew attention to pg 3 and said that we were suggesting any or all of the options noted. CB asked when our financial planning started. LB replied that it had already started. LF raised the idea of surveying actual members and seeking their views on future service provision. CB said she did not see the point of holding a workshop on the vision and values because who would disagree. CE gave the example that he believed the teaching of medical students had been left out and this was an important aspect. CB said that she fully appreciated the views of the Members' Council are important but that she felt at some point she must make contact with her constituency.

BG said it would be valuable to conduct a proper survey of the membership using a company such as MORI. CL said that we must be careful with surveys and be mindful of the way in which the questions are worded. CB said it is really the PCTs who need to find out what the local community wants as they are the commissioners of service. CE said that he understands from the discussion that the group might want to look beyond just aims and values. LF asked if the PCT would not fund the survey work as it was within their remit to understand the preferences of the local population. PM said that the PCT already undertakes extensive work to understand the needs of the local community, which in turn informs commissioning. NB said it would be useful to have some initial sessions with staff around values and aims. BG said that this had already been done last year. CE suggested that HL provide a date for the Trust to present the corporate plan to the Members' Council.

Action: HL to set date to present the corporate plan to the Members' Council.

2.2 Annual Audit Letter

CE said that it was important to understand the Audit Letter. HB said International Accounting Standards would be introduced as of next year for all trusts. Companies made the switch two years ago. The two key areas affected are private finance initiatives, which normally were off the balance sheet, and will now be reflected on the balance sheet. Second, more segmental analyses will be done. Details on the profitability of services will be provided with clear analyses of which areas are profitable and which are making a loss.

2.3 Local Area Involvement Networks (LINks)

AMC said that the Members' Council had agreed that an update on LINks should be made at the November Council meeting. The bill has been debated with three principal amendments to note: 1/Local councils must host the networks, 2/ the Department of Heath will provide more clear information on the transition, 3/ the bill received royal decree on October 31st. CE asked whether we were in danger of setting up a duplicate structure to the Members Council. Lydia Jackson, Chair of the Chelsea and Westminster Hospital Patient and Public Involvement Forum provided her understanding of the current situation. It was agreed that we would look towards ways of joint working.

2.4 Membership Report

CE said that he would address the next three papers together. He said that it was our statutory obligation to both grow our membership and ensure its diversity in relation to the local population. He noted the current figures for each membership constituency and that the actual figures for joiners and leavers has been provided to allow us to understand the success of our membership outreach. He said that the requirement to be in the trust for 12 months prior to joining the membership was not obligatory and he suggested that we might consider an opt-out approach for staff going forward. NB said he agreed with this suggestion as the requirement to fill in a form certainly put some people off. CL asked if we could have an opt-out policy for all patients. JC said that this would be very expensive, as we would have an enormous membership. Staff on the other hand have chosen to work for the Trust and it could be assumed would also want to support the Trust.

THE MEMBERS' COUNCIL UNANMOUSLY AGREED WITH THE PROPOSAL FOR AN OPT-OUT POLICY FOR STAFF.

Action: JC to discern the necessary changes to move to an opt-out system for staff.

2.5 Draft Minutes from Membership Development and Communications Sub-Committee

CE explained that Martin Rowell (MR) chaired the last committee meeting and invited him to present the report. MR raised point 4 and said that the committee had discussed the lower turn out for the AGM this year and that the group felt it was due to the fact that the supplementary meetings had been held on different days and that it was better to hold them on the same day.

MR said that overall membership numbers were important but that it is also important to look at the diversity of membership. Jane Collier, Equality and Diversity Manager, attended the committee meeting and she is planning to do an audit of the membership at our next meeting. He said it was the view of the committee that we represent a group of people that represent a larger group of people and they need access to Council Members.

CE raised the question if Council Members should be getting more involved in chairing sub committees. BG suggested that we might work more closely with PALS to seek the views of the membership.

IT WAS AGREED THAT THE TRUST WOULD CONSIDER HOLDING SUPPLEMENTARY EVENTS ON SAME DAY AS AGM

2.6 Membership Engagement

CE said that at the last Council meeting the issue of membership engagement had been discussed and that it was agreed that we would bring back a list of suggestions. He drew attention to the suggestion of ad hoc lobbying and said that paediatrics was the perfect opportunity for this. He suggested that fundraising might be added to the list. AMD asked if we could not have a dedicated e-mail box for members to contact their respective Council Member.

Action: Discuss further ways in which the Council will communicate with its members at the next meeting.

Action: Identify how members could e-mail their respective Council Members.

2.7 National Governors Forum

VA drew the Council's attention to the section on communications and the need for two-way feedback. She noted the idea about creating a buddy system where each member of the Board of Directors is paired with an individual Council Member. CE responded that this might be difficult as there are 35 members of the council and 11 on the Board. BG said we might also consider pairing clinical directors with Council Members.

Action: Further consideration of a system for members of the public and patient constituency to contact their respective Council Member.

2.8 Healthcare Commission Standards for Better Health

CM showed the Members' Council the 120 page report from last year. She explained the system for reviewing evidence with one lead director providing the evidence and a second acting as a peer reviewer. VA raised standard 15 and said that she had raised the possibility of getting a hostess for paediatrics with Sue Harris, but that the funding had not been found.

CE outline the options for involvement and said that his preference was option 2; whereby the Members' Council would identify the standards and/or areas for which they would like to contribute and one or more half day sessions would then be organised in January with lead directors present. PM said that the process used depends on the objective. Council Members could offer a means of external review and scrutiny of work already done by lead directors or we can develop a process to involve Council Members in judging evidence and whether or not the trust is compliant.

CB said she felt that the Council could not judge the actual evidence but rather whether it made sense. CM said that she hoped by involving the Council over time that they would become more familiar with the standards and give more input going forward. CM said that we are not looking for something perfect but that we have adequate level of assurance.

Action: Organise option 2 and people come prepared and know which standards they are interested in. Offer two dates in January.
Action: Circulate questions and ask if people want to get involved and in which areas.

2.9 Infection Control Update

CE invited Berge Azadian (BA), Director of Infection Prevention and Control to present his update. CE thanked BA for his presentation and said that it was his view that the key question from the public is "if I come into this hospital what is my risk of picking up MRSA?". CE raised the issue that some of the Trust's Healthcare Associated Infections are actually being brought in from the community. BA said pre-assessment screens all elective patients and those that are positive are treated. We have been doing this for 3 years. CE asked if some patients can avoid the screening. VA asked if we screen patients coming into A&E. BA said they did this at Charing Cross and they found that 5 out of 700 were positive. PM asked if patients admitted from A& E were screened prior to receiving a bed. BA responded that they were not. PM asked if there was not a case for screening all visitors.

2.10 Proposed Constitutional Change

CE said this amendment to the constitution is proposed in order to be compliant with the Mental Health Act 1983 (amended). It is effectively a change to allow the Trust to continue a practice which was permissible prior to becoming a Foundation Trust. We now require a constitutional amendment to continue the practice.

THE CONSTITUTIONAL CHANGE WAS AGRED.

3.1 Finance Report – 6 Months to September 07

The Council noted the report.

3.2 Performance Report – 6 Months to September 07

The Council noted the report.

QUESTIONS FROM THE PUBLIC

None

4. ANY OTHER BUSINESS

No other business was raised.

5. DATE OF NEXT MEETING

14 February 2008

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 14 February 2008

AGENDA ITEM NO.	1.4/Feb/08
PAPER	Matters Arising
AUTHOR	Julie Cooper, Foundation Trust Secretary
LEAD	Chris Edwards, Chairman
EXECUTIVE SUMMARY	This paper lists matters arising from previous meeting(s) and the action taken/to be taken.
DECISION/ ACTION	The Members' Council is asked to note the matters arising and update where appropriate.

Matters Arising from Previous Meetings

Reference	Item	Action
2.1/Nov/07	BUSINESS PLANNING HL to provide a date for the trust to present the corporate plan to the Members' Council.	HL
2.4/Nov/07	MEMBERSHIP REPORT JC to identify the necessary changes to move to an opt-out system for staff.	JC
2.6/Nov/07	MEMBERSHIP ENGAGEMENT 1. Discuss further ways in which the Council will communicate with its members at the next meeting. 2. Identify how members could e-mail their respective Council Members.	ALL JC
2.7/Nov/07	NATIONAL GOVERNOR'S FORUM Further consideration of a system for members of the public and patient constituency to contact their respective Council Member.	ALL/JC
2.8/Nov/07	HEALTHCARE COMMISSION STANDARDS FOR BETTER HEALTH 1. Organise option 2 and people come prepared and know which standards they are interested in. Offer two dates in January. 2. Circulate questions and ask if people want to get involved and in which areas.	JC/CM JC

Members' Council Meeting, 14 February 2008

AGENDA ITEM NO.	1.5/Feb/08
PAPER	Chairman's Report
AUTHOR	Chris Edwards, Chairman
LEAD	Chris Edwards, Chairman
SUMMARY	This report outlines key issues for the attention of the Members' Council.
DECISION/ ACTION	The Council is asked to note the report.

Chairman's Report

1.0 WELCOME TO NEW MEMBERS

I want to welcome our 8 new members to the Members' Council. We will be running an induction for new members and any existing members who wish to attend on 7 February.

The new Council Members and the constituency they represent are listed below:

Staff, Nursing and Midwifery
Sue Smith

Patient Constituency
Sue Smith
June Bennett
Walter Balmford

Public Constituency, Kensington and Chelsea Area 1
Raymond Levy

Public Constituency, Wandsworth Area 1
Mary Symons

Public Constituency, Westminster Area 2
Martin John Lewis

Public Constituency, Hammersmith and Fulham Area 1
Martin Bradford

2.0 NEW FOUNDATION TRUST WEBSITE

I am pleased to inform you that the Foundation Trust section of the main hospital website has now been updated and I want to thank all of you who provided your information as well as input. For all new members, I would ask that you provide both a photo (electronic if possible) and your profile to Matt Akid, Head of Communications. Matt.akid@chelwest.nhs.uk. I believe a separate communication has already gone out to this effect. I would also ask that you share any feedback on the new site with Matt either by e-mail or phone on 0208 846 6828.

3.0 THAMES VALLEY UNIVERSITY

Nursing and Midwifery Education is provided within Higher Education in partnership with the NHS which provides the bulk of clinical placements for students. NHS London is responsible for the educational contracts with Universities in the capital.

The Trust has written to NHS London indicating that it will cease offering clinical placements to pre-registration nursing and midwifery students from Thames Valley University from March 2008. The Trust will honour its commitment on existing student placements until August 2008. However the Trust will work flexibly with TVU and NHS London over this period, to ensure that the impact on current students is minimised.

The Trust has taken this decision after raising issues of concern with TVU and NHS London. The Trust feels that sufficient progress has not been made to address the Trusts concerns and as such has ceased to offer clinical placements to TVU students.

The Trust is committed to offering its excellent clinical placement opportunities to other universities through a selection process as soon as is practically possible.

Prof. Chris Edwards
Chairman
February 2008

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council
Register of Interests

NAME	INTEREST(S)
Arana, Ms Maria-Elena Patient	
Arends, Ms Valerie Public – Kensington and Chelsea 2	No interests to declare
Balmford, Mr Walter Patient	
Bennett, Ms June Patient	
Blewett, Mrs Christine Hammersmith and Fulham 2	• Employee of Westminster PCT – co-director of Local Community Contraceptives Services
Bradford, Mr Martin Public – Hammersmith and Fulham 1	
Browne, Ms Nicky Partnership – Royal Marsden NHS FT	
Delamare, Ms Alison Staff - Contracted	
Edwards, Prof Chris Chairman	Chairman of EasiGeothermal and Newcastle university Ideas Bank Non-Executive Director of Carbon Neutral North East Non-Executive Director of NUballast
Fitzgerald, Mr Hugo Patient	No interests to declare
Foulkes, Mr Lionel Public – Wandsworth 2	
Gazzard, Prof Brian Staff – Medical & Dental	I received ad hoe payments of grants from a variety of pharmaceutical companies
Henry, Mr Michael Patient	

Updated January 2008

NAME	INTEREST(S)
James, Ms Cathy Staff – Support, Admin & Clerical	No interest to declare
Jowett, Prof Sandra Partnership – Thames Valley University	Staff member from Thames Valley University
Levy, Mr Raymond Public – Kensington and Chelsea 1	
Lewis, Mr Martin Joihn Public – Westminster 2	
Mills-Duggan, Ann Public Westminster	I work for a pharmaceutical company
Molyneux, Mr Peter PCT – Kensington and Chelsea	Chair at K and C PCT
King, Miss Jane Patient	No interests to declare
Longworth, Ms Catherine PCT - Westminster	No interest to declare
Macrae, Dr Duncan Partnership – Royal Brompton NHS Trust	
Symons, Ms Mary Public – Wandsworth 1	
Vacant Local Council - Westminster	
Maze, Prof Mervyn Academic - Imperial	No interests to declare
Rawaf, Prof Salman PCT – Wandsworth	Executive Director PCT, Chair International Committee of Faculty of Public Health, Director Of Wandsworth WHO Collaborating Centre, Editor Journal of Public Health Medicine
Rowell, Mr Martin Patient	No interests to declare
Smith, Mrs Sue Staff – Nursing and Midwifery	No interests to declare
Smith, Mr James-Jim Patient	No interests to declare

NAME	INTEREST(S)
Smith, Ms Sue B Patient	
Taylor, Cllr Frances Local Council – Kensington and Chelsea	Member: friends of Governor / All others as per RBKC website
Vacant Staff – Management	
Wood, Ms Vivian PCT – Hammersmith and Fulham	No interests to declare

Members' Council Meeting, 14 February 2008

AGENDA ITEM NO.	2.1/Feb/08
PAPER	Business Planning 2008/09
AUTHOR	Amit Khutti, Director of Strategy and Service Planning
LEAD	Lorraine Bewes, Director of Finance and Information
SUMMARY	The membership and the Members' Council play a vital role in providing a community perspective to service development. The annual service planning process sets out a clear and shared vision amongst staff, members and external stakeholders of how the Trust and individual directorates will develop over the next 12 months. This paper is a mechanism for involving the Members' Council in the development of the annual plan and specifically invites feedback on the deliverables set out in the plan.
DECISION/ ACTION	The Council is asked for feedback on the deliverables set out in this paper.

ANNUAL PLANNING FOR 2008/09

CONTEXT

As discussed at the Members Council meeting on 8th November 2007, according to the Trust constitution one of the Members Council's roles and responsibilities is to:

"to provide their views to the Board of Directors when the Board of Directors is preparing the document containing information about the Foundation Trust's forward planning" (7.3.1.2.).

We are now in the midst of annual planning for 2008/09, and would value Members Council feedback on those activities the Trust is prioritising for next year. Key elements of the annual planning process so far have been as follows:

C&W Board agrees overall approach to annual planning and agrees headline Trust corporate objectives	Board agreed at meeting on 28/11/2007
C&W Executive team draft Trust-wide deliverables beneath each headline corporate objective	Drafted at various meetings in December 2007
Departments within the Trust asked to develop own deliverables and to show how they align with the headline Trust corporate objectives	Guidance and timeline issued week commencing February 11th

The Executive team will be meeting with the Trust departments over coming weeks to discuss and challenge their emerging plans. All plans will eventually need to be combined into an overall Annual Plan which we will submit to the Foundation Trust regulator Monitor by the end of May 2008. We intend to bring a draft of this Annual Plan document to the May meeting of the Members Council.

WHAT WOULD WE LIKE FROM YOU?

The Board has agreed the top 5 Corporate Objectives for the Trust in 2008/09. The Trust Executive has drafted deliverables beneath each corporate objective. Both the Corporate Objectives and draft deliverables are listed beneath. A final table sets out the rationale for each of the draft deliverables. We would welcome input from the Members Council on the following questions:

1. Do the draft deliverables beneath each Corporate Objective seem sensible and stretching targets for 2008/09?
2. Taken together, do you think each group of draft deliverables will help to deliver the overall Corporate Objective?
3. Are there any significant gaps between the Corporate Objectives and the deliverables?

TRUST CORPORATE OBJECTIVES AND DRAFT DELIVERABLES 2008/09

TRUST CORPORATE OBJECTIVES FOR 2008/09

1) **Focus on patient safety and quality**
2) **Deliver effective and efficient pathways of care**
3) **Be the provider of choice**
4) **Deliver excellence in teaching and research**
5) **Create robust infrastructure for the future**

TRUST CORPORATE OBJECTIVES WITH ASSOCIATED DRAFT DELIVERABLES FOR 2008/09

1) **Focus on patient safety and quality**
   a) Achieve consistent improvement as benchmarked through best practice
   b) Deliver target reductions in healthcare acquired infections
   c) Maintain CNST level 2 and make progress towards CNST level 3

2) **Deliver effective and efficient pathways of care**
   a) Deliver the 18 weeks target in full by December 08 then sustain performance and identify areas where can go further
   b) Work in partnership with PCTs to deliver recommendations from the consultation on Healthcare for London: A Framework for Action
   c) Introduce case-management of patients
   d) Achieve key financial targets

3) **Be the provider of choice**
   a) Improve patient satisfaction
   b) Redefine and develop the ‘Chelsea & Westminster Offer’ to staff
   c) Secure a larger patient base for the Trust in collaboration with PCTs and other providers

4) **Deliver excellence in teaching and research**
   a) Deliver excellence in teaching
   b) Implement the research strategy
   c) Lead a Collaboration for Leadership in Applied Health Research and Care

5) **Create robust infrastructure for the future**
   a) Provide excellent administrative processes for elective patient pathways
   b) Ensure services have strong clinical leadership and managerial and corporate support to enable increased devolution of responsibility to front line services
   c) Maintain robust governance and assurance processes
   d) Agree and approve a migration path from Lastword to an alternate system

Corporate Objectives and deliverables –Rationale

Corporate Objective	Key deliverables	Rationale for this deliverable
1) Focus on patient safety and quality	Achieve consistent improvement as benchmarked through best practice	The Trust already centrally tracks and monitors numerous indicators of patient safety and quality including infection rates, emergency readmissions following discharge and the incidence of Serious Untoward Incidents. Front line services will also generally audit and track their own safety and quality measures. We are keen to further develop and systematise the benchmarking and monitoring of key indicators of patient safety and quality. The Trust Executive will work with each clinical service to develop a series of safety and quality metrics that are relevant to that service, and also provide each service with access to meaningful benchmarking information.
	Deliver target reductions in healthcare acquired infections	Public concern over healthcare acquired infections (HCAIs) remains high. Continued reductions in these infections are a government priority for 2008/09 and beyond. As a Trust we have a good record on tackling HCAIs, and we will continue to implement measures to tackle all HCAIs. In 2008/09 we will have a particular focus on reducing rates of *Clostridium Difficile* and of further reducing cases of MRSA blood infections.
	Maintain CNST level 2 and make progress towards CNST level 3	The Clinical Negligence Scheme for Trusts (CNST) is a means for NHS organisations to fund the cost of clinical negligence claims. The scheme is divided into standards set at three 'levels': one, two and three. The Trust has already achieved CNST level 2 and wishes to maintain this level and make progress towards the highest level, CNST level 3. Trusts which meet the higher levels have to meet exacting clinical risk management standards. The process of meeting the standards for CNST level 3 should help to ensure the Trust has effective risk management activities which should deliver quality improvements in patient care and the safety of patients, staff and visitors. Trusts which meet higher levels of CNST are also awarded significant

		discounts on their CNST contributions.
2) Deliver effective and efficient pathways of care	Deliver the 18 weeks target in full by December 08 then sustain performance and identify areas where can go further	Shorter patient waiting times remains a key priority for the NHS, and we must ensure delivery of the target of patients waiting no more than 18 weeks from referral to treatment. By December 08 we will ensure that at least 90% of pathways where patients are admitted for hospital treatment and 95% of pathways where patients are treated without being admitted are completed within 18 weeks. In some areas we are likely to be able to reduce waits below 18 weeks, which will be of benefit to patients and also help us act as a provider of choice. Our host PCT has indicated an interest in working with us to identify specialities where this is feasible.
	Work in partnership with PCTs to deliver recommendations from the consultation on *Healthcare for London: A Framework for Action*	Consultation on the London review *A Framework for Action* will end in February 08. PCTs will be looking to implement recommendations from this consultation, and we need to start planning now to deliver recommendations that are likely to affect our Trust. The specific deliverables below are all linked to recommendations from the *Framework* which we expect to see endorsed through the consultation process. • Deliver public health targets including in obesity, smoking, substance misuse and sexual health • Achieve a primary care front-end to A&E • Review and improve maternity offer • Provide a comprehensive children's service • Improve stroke outcomes • Enhance community support for chronic disease management • Consistently implement best practice palliative care

	Introduce case-management of patients	We want to offer a distinctive service to patients by improving the coordination of their entire pathway of care. In 2008/09 we want to pilot a case-management approach for patients in a specific service in which patients and carers would be given a single point of contact at the Trust. A patient's case-manager would be charged with ensuring a smooth, individualised approach to a patient's care. We will need to develop details of how the pilot might work, but it would likely involve different levels of case-management based on complexity of the patient pathway. For example, for a straightforward procedure for a fit and well-organised patient it might involve a phone-call reminder in advance of an operation, pointing the patient in the direction of relevant pre-op information and then a follow-up call after the operation to check on progress and patient satisfaction. For a much more complex pathway where, for instance, a complicated procedure was needed on a patient with learning disabilities, a more intensive case-management approach would be used. This might include a home visit, prioritisation of the patient during an outpatient visit to reduce anxiety, a discussion with the operating consultant, and again a follow-up phone call.
	Achieve key financial targets	As with all NHS organisations, we have a responsibility to deliver value for money from our healthcare expenditure. As a Foundation Trust, we must ensure we create a sufficient surplus each year to invest in maintaining and developing our services. To this end the Board has agreed that we should aim to deliver a financial performance which maintains our excellent financial rating of '5 out of 5' or 'low risk' as assessed by Monitor, the Foundation Trust regulator.
3) Be the provider of choice	Improve patient satisfaction	As well as providing high quality healthcare services, the Trust is also keen to make sure it is delivering a quality patient experience. In addition, with the advent of increased patient choice over the location of their treatment, we need to ensure we are meeting patient expectations.

		To this end we are keen to introduce better methods of measuring, monitoring and reacting to patient and carer feedback. We are in discussion with various companies about improving the value we get from the mandatory national patient survey, and supplementing this with more innovative approaches such as mechanisms for systematically collective real-time or near real-time patient feedback.
	Redefine and develop the 'Chelsea & Westminster Offer' to staff	Our staff work extremely hard to deliver high-quality services at Chelsea & Westminster, as is reflected in our being one of only three Trusts in London rated as 'Excellent' by the Healthcare Commission. The Trust Executive recognises that delivering this performance can be challenging for staff, as is fed back to us via the staff survey. We want to explore with staff (e.g. via staff workshops and surveys) what can and should they expect to gain from coming to work at our Trust. This will not focus on a benefits package, although this may be relevant for some staff. Rather the focus is likely to be on issues such as providing a satisfying career rather than simply a job, re-exploring opportunities for flexible working and engaging staff with the Trust vision and values.
	Secure a larger patient base for the Trust in collaboration with PCTs and other providers	There is a general move to consolidate more complex, specialist services in fewer hospitals. The consultation *Healthcare for London: A Framework for Action* gave further impetus to this move, suggesting a distinction between 'Local hospitals' as opposed to 'Major acute' and 'Specialist' hospitals where higher volumes of more specialist work would be consolidated. We have a cohort of specialist services including HIV, high-risk maternity and specialist paediatrics, underpinned by an excellent anaesthetic and critical care infrastructure. To ensure we are well placed to maintain and to strengthen these services, we will want to be considered either a 'Major acute' hospital or a 'Specialist' hospital for certain services. In either of these cases, we will need to have referrals coming in from a wider geographic area, and will need to work with PCTs and other providers to secure this larger patient base.
4) Deliver excellence in teaching and	Deliver excellence in teaching	There is good evidence that having a strong teaching and research environment in a healthcare organisation matches improved patient outcomes. We are keen to foster a strong learning environment for the staff

research		at our Trust which we are confident will lead to better patient care. We will be monitoring and looking to improve the feedback that we get from our students.
	Implement the research strategy	Changes to the way in which R&D is funded and managed nationally require that Chelsea and Westminster NHS Foundation Trust, in line with other NHS organisations, review the structure, organisation and delivery of research. Research within the Trust has traditionally been led by individuals or groups of investigators rather than being part of an integrated research programme. A research strategy has now been approved by the Trust Board which includes the establishment of an Academic Board to oversee the development of an integrated programme of research activity. We are keen to progress implementation of this strategy during 2008/09.
	Lead a Collaboration for Leadership in Applied Health Research and Care	The National Institute for Health Research has called for proposals from collaborations of healthcare and academic organisations in a geographic area wishing to work together to undertake high-quality applied health research and to support the translation of research evidence into practice in the NHS. The Trust has applied to be a lead organisation in such Collaboration with a view to securing funding from the National Institute to support this development.
5) Create robust infrastructure for the future	Provide excellent administrative processes for elective patient pathways	We are keen to make the elective patient pathway as smooth and as efficient as possible. In 2008/09, the Trust will make a concerted effort to improve our performance in a number of key areas including: • Improving theatre productivity, one of the Trust's most expensive resources; • Reducing the incidence of patients not attending appointments • Improving discharge planning and ensuring high quality electronic discharge summaries are sent to all GPs
	Ensure services have strong clinical	Our Trust was fortunate to be amongst the first NHS pilots for the introduction of 'Service Line Reporting' – a new way of understanding the economics of

	leadership and managerial and corporate support to enable increased devolution of responsibility to front line services	service lines such as Trauma and Orthopaedics or Cardiology. We are now keen to move beyond Service Line Reporting towards increased Service Line Management – putting more responsibility and accountability in the hands of these individual service lines, so that over time greater control rests closer to the front line. This will likely involve a significant, multi-year organisational change programme. To enable this increased devolution, in 2008/09 we want to focus on making sure these services have the right level of clinical and managerial leadership and support, and that they are also well supported by corporate functions such as finance and information and HR.
	Maintain robust governance and assurance processes	This will ensure that the trust operates as efficiently and effectively as possible and that we have systems in place to ensure safe and high quality care for patients and a safe and productive environment for staff. Good governance also ensures that the Trust operates legally and according to best practice. Having effective assurance mechanisms in place is important to ensure that high quality information is available to the right people and that there are systems to allow challenge. It encourages people to ask, how do we know? What is the evidence? Having assurance processes in place is part of ensuring safety and quality.
	Agree and approve a migration path from Lastword to an alternate system	We have been notified by GE our supplier for our patient administration system Lastword that they will not support the system beyond Dec 08. We need to start planning now for an alternate system, and agree how we will manage the migration of information and users from our current system.

Amit Khutti
Director of Strategy and Service Planning
6th February 2008

Members' Council Meeting, 14 February 2008

AGENDA ITEM NO.	2.2/Feb/08
PAPER	Proposed Amendments to the Constitution
AUTHOR	Julie Cooper, FT Secretary/Head of Corporate Governance
LEAD	Prof Chris Edwards, Chairman
SUMMARY	This paper outlines proposed changes to the constitution regarding the staff constituency. The change to move to a staff opt-out system has already been agreed by the Members' Council at the last Council meeting.
DECISION/ ACTION	The Council is asked to discuss and approve the proposed changes, which will then be submitted to Monitor for approval.

1. Introduction
The Members' Council voted unanimously for a move to an opt-out system for staff at the Members' Council meeting in November 2007. The Foundation Trust secretary was to confirm the process that needed to be followed to implement this change. Subsequent to this, there have been three further suggestions for changes to the constitution with regards to the staff constituency and these are outlined below.

2. Process to change the constitution

Our Constitution states that no amendment shall be made to the provisions of the constitution concerning the staff constituency or the classes of the staff constituency unless it has also been approved by a majority of the members of all of the classes of the staff constituency as may have voted at a members meeting. In adherence with this requirement, a meeting of all of the current staff members will be called at which time will present the proposal to move to an opt-system for staff and take a vote.

3. Further proposed changes

3.1 Staff constituencies - the issue
As part of the process to implement the opt-out system for staff it was noted that the staff categories stipulated in the constitution do not correspond with those currently used by Human Resources. In addition, the lack of a candidate for the management constituency may indicate that the membership of this constituency is poorly understood and/or that it is very small.

3.2 Proposal
It is proposed that the category of 'Support, Administration and Clerical' be merged with the category 'Management' which should then cover all staff not already falling under one of the other four categories.

3.3 Members – the issue
The constitution currently states that membership is open to any individual who meets certain key criteria including completing a membership application form in what ever form the Secretary specifies.

3.4 Proposal
An additional line should be added to line 8.2.3 which states for staff members the process outlined in section 8.7.2.4 shall apply.

3.5 Volunteers – the issue
The constitution specifically states that volunteers would not be eligible to become staff members. See extract 8.7.2.2 in the appendix. There is no reference to this specifically in the model constitution, only that staff members must have a contract of employment or be employed continuously for over a year. It is not clear why volunteers are specifically excluded if they meet the other criteria. In practice the majority would be eligible to become public or patient members.

3.6 Proposal
It is proposed that the statement excluding volunteers from becoming staff members is removed.

4.0 The Proposed Changes to the Constitution
The current wording and the proposed wording is as attached at appendix 1.

5.0 The Process
The Foundation Trust Secretary will call a meeting of all members of the staff constituency to make the proposal to change the relevant sections of the constitution to allow for an opt-out system. A vote will then be taken.

If agreed by the majority of the staff constituency at the above mentioned meeting, a letter from the Chairman explaining the changes will be sent to all Trust staff with their pay slips. Staff will be given approximately one month to choose not to become a member. An explanation will be given with regards to the transfer of personal data into the membership database and for what purpose this data will be used.

In parallel, the Trust Secretary will brief the next JMTUC staff side meeting to explain the rationale for the move to an opt-out system for staff and for the change in the staff constituencies. She will respond to any concerns that may arise and ensure that all appropriate steps are being taken.

A notice explaining the change will be included in Trust news and it will be raised in team briefing. The volunteers will be informed of the change.

If approved, the migration of all staff to the FT membership database will take place using the new categories. .

6. Action required
The Members' Council is asked to approve the above changes to the constitution.

7.0 Future Amendments to the Constitution
In following the process for making the above proposed changes to the constitution it has become apparent that the procedure is cumbersome and time consuming. We would ask the Members' Council to consider that we propose to change the section of our constitution governing amendments to the constitution at the next Annual Members' Meeting along the lines of the text below which would be in line with most other Foundation Trusts.

> ***Amendment of the Constitution***
> *The Trust may make amendments to the constitution with the approval of Monitor.*
>
> *No proposal for the amendment of this constitution will be put to Monitor unless it has been approved by three quarters of the Members' Council.*

Appendix 1

Current wording of the constitution and proposed changes

Section 2 Definitions

'Staff constituency' means (collectively) those members of the six classes comprising the staff constituency'

Section 8.7 Staff constituency

Current wording

8.7 Staff constituency

8.7.1. The staff constituency is divided into six classes as follows:

8.7.1.1. Support, Administrative and Clerical staff

8.7.1.2. Allied Health Professionals, Scientific and Technical staff

8.7.1.3. Contracted staff.

8.7.1.4. Medical and Dental staff

8.7.1.5. Nursing and midwifery

8.7.1.6. Management.

8.7.2. Membership of one of the classes of the staff constituency is open to individuals:

8.7.2.1. who are employed under a contract of employment by the Foundation Trust and who either

8.7.2.1.1. are employed by the Foundation Trust under a contract of employment which has no fixed term or a fixed term of at least 12 months, or

8.7.2.1.2. who have been continuously employed by the Foundation Trust or the NHS Trust for at least 12 months; or

8.7.2.2. who are not so employed but who nevertheless exercise functions for the purposes of the Foundation Trust and who have continuously exercised the functions for the purposes of the Foundation Trust or the NHS Trust for at least 12 months. For the avoidance of doubt, this does not include those who assist or provide services to the Foundation Trust on a voluntary basis.

Section 11 Members Council

The Members' Council of the Foundation Trust is to comprise…

11.4.3. six Staff Council Members from the following classes;

11.4.3.1. Support, Administrative and Clerical staff – one Staff

Council Member;

11.4.3.2. Allied Health Professionals, Scientific and Technical staff – one Staff Council Member;

11.4.3.3. Contracted staff – one Staff Council Member;

11.4.3.4. Medical and Dental staff – one Staff Council Member;

11.4.3.5. Nursing and midwifery – one Staff Council Member;

11.4.3.6. Management – one Staff Council Member;

4.3 The Proposed Changes

Section 2 Definitions

'Staff constituency' means (collectively) those members of the five classes comprising the staff constituency'

Section 8.7 Staff constituency

8.7.1. The staff constituency is divided into five classes as follows:

8.7.1.1. Management, Support and Administrative and Clerical staff

8.7.1.2. Allied Health Professionals, Scientific and Technical staff

8.7.1.3. Contracted staff

8.7.1.4. Medical and Dental staff

8.7.1.5. Nursing and midwifery

8.7.2. Membership of one of the classes of the staff constituency is open to individuals:

8.7.2.1. who are employed under a contract of employment by the Foundation Trust and who either

8.7.2.1.1. are employed by the Foundation Trust under a contract of employment which has no fixed term or a fixed term of at least 12 months, or

8.7.2.1.2. who have been continuously employed by the Foundation Trust or the NHS Trust for at least 12 months; or

*8.7.2.2. who are not so employed but who nevertheless exercise functions for the purposes of the Foundation Trust and who have continuously exercised the functions for the purposes of the Foundation Trust or the NHS Trust for at least 12 months. [*For the avoidance of doubt, this does not include those who assist or provide services to the Foundation Trust on a voluntary basis]. **DELETE**

ADDITION

8.7.2.3 have each made an application for membership of the NHS Foundation Trust or

8.7.2.4 have been invited by the Trust to become a member of that constituency and have not informed the Trust that they do not wish to do so.

Section 11 Members Council

The Members' Council of the Foundation Trust is to comprise…

11.4.3. five Staff Council Members from the following classes;

11.4.3.1. Management, Support and Administrative and Clerical staff – one Staff Council Member;

11.4.3.2. Allied Health Professionals, Scientific and Technical staff – one Staff Council Member;

11.4.3.3. Contracted staff – one Staff Council Member;

11.4.3.4. Medical and Dental staff – one Staff Council Member;

11.4.3.5. Nursing and midwifery – one Staff Council Member;

Chelsea and Westminster Healthcare NHS
NHS Trust

Members' Council , 14th February 2008

AGENDA ITEM NO.	2.2/Feb/08
PAPER	Performance Report
LEAD EXECUTIVE	Lorraine Bewes – Director of Finance and Information
AUTHOR	Nick Cabon – Head of Performance & Information
SUMMARY	The purpose of this report is to provide information about the Trust's performance for the period ending 31st December 2007. The Trust must focus on the following targets to ensure performance is either 'Excellent' or 'Good' as assessed by the Healthcare Commission: • The MRSA where we have had 13 cases by mid-January versus a year-end target of 12; • Outpatient Waiting Times where we cannot afford any more breaches of the 13 week maximum wait; • The 18 weeks target, which is dealt with in a separate report. The exact performance assessment by the Healthcare Commission will depend on the thresholds they set for 'Underachieving' versus 'Failing' a target, but we must deliver a strong performance through to year-end.
BOARD ACTION	The Members' Council is asked to note and discuss the report and actions.

Chelsea and Westminster Healthcare NHS

NHS Trust

PERFORMANCE REPORT FOR THE PERIOD DECEMBER 2007

1. PURPOSE

1.1. The purpose of this report is to provide information about the Trust's performance for December 2007. The Members' Council is asked to note the report and conclusions.

2. CONTENT OF PERFORMANCE REPORT

2.1. The report comprises of the following components:

- **External Dashboard – pg 5**
- **Internal Dashboard – pg 6**
- **Appendices**
  - **Activity Summary – pg 7**
  - **Efficiency and Resources Summary – pg 8**
  - **Access Summary – pg 8**
  - **Clinical Coding – pg 9**
  - **Infection Control – pg 10**
  - **Theatre Efficiency – pg 11-13**
  - **HR Summary – pg 14**
  - **SLA Performance Summary – pg 15-16**

3. SUMMARY OF PERFORMANCE REPORT

3.1. In terms of Monitor targets, the Trust is not meeting the Outpatient waiting times target. There have been 11 breaches reported so far this year. We are also off trajectory for the MRSA target for the third quarter with 12 cases by the end of December versus a trajectory of 9.

3.2. The MRSA and Outpatient waiting time targets are also monitored by the Healthcare Commission. We have in fact had another case of MRSA in January 2008, bringing the year-to-date total to 13 versus the annual target of 12. However, we will still argue for our target to be increased to 15 in line with the correct calculation of our trajectory, and are raising a case for extenuating circumstances with the Healthcare Commission. We have had eleven breaches of the Outpatient target. At this number of breaches we are likely to be just within tolerance to achieve this indicator for the whole year.

3.3. There has also been a breach of the cancer 2 week wait target in gynaecology. The year-to-date performance is 99.8% so still well above the target.

3.4. Our performance is slightly below target for patients offered a GUM appointment within 48 hours, with performance in December of 99% against the target of 100%. We anticipate achieving 100%.

3.5. The Trust must ensure that patients do not wait longer than 6 weeks for diagnostic tests throughout March 2008. Currently our performance is at 84.4%.

3.6. We are on track to meet all other Healthcare Commission targets and are on schedule with our internal indicators other than the Clostridium Difficile target agreed with our local PCT and our target on 'Emergency readmissions following discharge for fractured hip'.

4. EXTERNAL TARGETS

4.1. We have not had any breaches of the outpatient waiting times target in December. There have been 11 breaches so far this year and we cannot afford any further breaches if we are to achieve this target.

4.2. The Trust is above trajectory for the MRSA target and we now need to ensure that there are no further cases this year.

4.2.1. There had been 12 cases by the end of December including two during the month – one on the Acute Medical Unit and one on Nell Gwynne ward. There has also been a further case in January bringing our total to 13 cases for the year. We have notified Monitor that we are not on track to meet this target and they have asked for monthly updates on the number of cases and on our action plan. Our Trust target for the year is a maximum of twelve cases of MRSA.

4.2.2. It is unclear what the tolerance between "under achieving" and "failing" this target would be. The Healthcare Commission criteria in 2006/7 was "missing the target by a significant amount" in order to fail. If the Trust was to miss the target by two cases this would represent a difference of 16% on plan. This might be interpreted as a "significant amount" in percentage terms, but the Trust would argue that in absolute terms it is only a small amount.

4.3. Our performance is slightly below target for patients offered a GUM appointment within 48 hours. The performance in December was 99% versus a target of 100% by 2008, although our performance does compare favourably against other Trusts. The HIV/GUM directorate has confirmed their commitment to achieving the 100% through to year-end.

4.4. The Trust needs to improve its performance relating to waiting times for diagnostic tests. Performance will be assessed during March, but currently we are at 84.4% compared with the 100% target. Each directorate has been asked to devise an action plan for those areas where their performance falls below 100%.

4.5. There was a breach of the 2 week cancer wait target in December 2008. It is the first breach this year, and our performance is still above the 98% threshold. The breach occurred in gynaecology and was due to a clinic being cancelled on the day due to a doctor not being available. The patient was given another appointment, but it was after the breach date. Although the target is not at risk, these breaches do not reflect good patient care and an internal review panel is investigating the incident.

4.6. We are still on track to meet other Healthcare Commission targets but need to assess ourselves internally against six targets such as 'Obesity: Compliance with NICE guidelines' which will be based on special data collections by the Healthcare Commission on the 31st of March 2008.

5. INTERNAL INDICATORS

5.1. The Trust is on track to achieve all of its internal indicators with the exception of the Clostridium Difficile target agreed with our local PCT and the 'Emergency readmissions following discharge for fractured hip' indicator.

5.1.1. The graph on page 10 shows the numbers of Clostridium Difficile infections per directorate. It shows that the numbers of cases have dropped significantly over the past 4 months.

5.1.2. Performance against the 'Emergency readmissions following discharge for fractured hip' indicator has improved slightly but remains higher (worse) than the target.

5.2. A report on progress towards the 18 week target is detailed in a separate paper.

6. ACTIVITY AND SLA PERFORMANCE SUMMARY

6.1. The net position against our Service Level Agreements is £345k (0.26%) below plan at the end of December 2007.

6.2. Under-performance is driven by lower Elective Inpatient and Daycase activity than envisaged in the SLA plans (total underperformance of £2,277k or 11% of plan). However, the SLA plans spread extra activity to achieve the 18 weeks target across the year rather than in the last six months of the year; as a result, the plans overstate the underperformance of elective activity. To see actual planned activity to meet the 18 weeks target, please refer to the separate 18 week paper.

6.3. Underperformance on elective activity is offset by higher than planned non-elective activity. There is significant over-performance in obstetrics (£950k or 15% above plan). There is also over-performance in Hand Management (£1,319k), however this partly relates to a re-classification of Hand Management as non-elective activity rather than elective Plastic Surgery activity which is under-performing. The combined performance of elective and non-elective Hand Management and Plastic Surgery is £734k ahead of plan.

6.4. There are several issues commissioners have raised about our current contract performance:

6.4.1. Adult Critical Care continues to under-perform significantly against plan. Activity plans included counting low-intensity Level 1 bed-days when these should actually have been counted as an overhead into a re-priced tariff for higher acuity critical care. Our financial losses versus plan is being capped at 20% (£1,122k) of planned income as per national guidance, but we may face a further pressure next year.

6.4.2. Commissioners are challenging the basis of an increase in Dermatology Regular Day Attenders which was not factored into plans. If we cannot satisfy commissioners that this additional activity is genuine and not the result of coding changes, our income will be capped to plan.

6.4.3. We are also being challenged on 'duplicate' Outpatient attendances where commissioners want us to demonstrate that these reflect genuine multi-disciplinary clinics rather than a recording issue.

6.4.4. We have fully provided for all of the issues raised above in the financial forecast.

6.5. In terms of individual PCT performance, we are over-performing against Hammersmith & Fulham PCT and Ealing PCT and under-performing against Kensington & Chelsea and Westminster PCTs.

7. HR INDICATORS

7.1. The number of staff in post has been consistently higher this year compared with 2006/7, and consequently the vacancy rate is lower.

7.2. During the early part of the year the levels of bank usage were much lower than last year, but this is no longer the case.

7.3. Agency rates have been consistently higher each month this year compared with last, and so far they have been 54% higher than in the first nine months of last year.

7.4. The sickness rate for December was up to 4.7% - 21% higher than in 2006/7.

8. EFFICIENCY AND RESOURCES

8.1. Overall average length of stay is lower than the target. This is driven by lower non-elective average length of stay. However, elective length of stay is better than in 2006/7, but a little higher than the target.

8.2. The Trust's new to follow-up rate for outpatients is currently ahead of target at 1:1.86 versus a Trust level target of 1:1.96. However, there are financial penalties for failure to meet new to follow-up rates at specialty level which are masked at Trust level.

8.3. Analysis of theatre utilisation is shown on pages 11 to 13. It shows that a higher percentage of sessions and theatre time are being used than last year, but the average number of cases per list is down compared with 2006/7. Also, 53% of main theatre sessions started at least 30 minutes late; the corresponding percentages were 58% for paediatric theatres and 46% for the treatment centre.

8.4. The Trust's internal target is for no more than 10% of sessions to start more than 30 minutes late. Improving theatre productivity is going to be an area of increased focus in 2008/09, as part of the Board-agreed corporate objective around 'building a robust infrastructure'. Questions have also been raised about the accuracy of reporting on theatre productivity, which we are investigating.

9. CONCLUSION

9.1. The key performance issues are the delivery of the MRSA target; ensuring that we do not have any further breaches of the outpatient waiting time target; reducing diagnostic waiting times to less than 6 weeks; and delivering the 18 weeks target.

9.2. To retain an "Excellent" rating for Quality of Services in 2007/08, the Trust will need to meet the core standards, most likely deliver all of the targets above other than MRSA and also meet the requirements of the indicators assessed by special collection at the end of March.

Nick Cabon
Head of Performance and Information
18th January 2008

Dashboard

	Indicator Name	Target	YTD Performance	Expected Performance at year end	Trend on Last month	Monitor Score - Year to Date	Monitor Score Expected Year End	Healthcare Commission Score - Year to Date	Healthcare Commission Score - Expected Year End
Monitor Indicators weighted 1.0	Cancer patients waiting 31 days from decision to treat to first treatment	98%	98.9%		↓	0.00	0.00	3	3
	Cancer patients waiting 62 days from GP referral to first treatment	95%	100.0%		↔	0.00	0.00	3	3
	Elective Booking	100%	100.0%		↔				
	Outpatient Booking	100%	100.0%			0.00	0.00	3	3
	Elective patients waiting longer than the standard (6 months)	0.03%	0.00%			0.00	0.00	3	3
	Outpatients waiting longer than the standard (13 weeks)	0.03%	0.04%			1.00	0.00	1	3
	48 hour Access to GUM Clinics -Offered	100%	97%		↑	1.00	0.00	1	3
	48 hour Access to GUM Clinics -Seen	n/a	76%						
	MRSA - Cases	9	12		↓	1.00	1.00	0	1
Monitor Indicators weighted 0.4	Cancer patients waiting 2 weeks from GP referral to first appointment	98%	99.8%		↓	0.00	0.00	3	3
	Cancelled Operations rebooked within 28 days *	100%	100.0%		↔				
	Delayed Transfers of Care	3.5%	2.7%		↓	0.00	0.00	3	3
	Total time in A&E (4 hours or less)	98%	98.5%		↓	0.00	0.00	3	3
	Waiting times for the rapid access chest pain clinic	99%	100.0%		↔	0.00	0.00	3	3
						3.00	**1.00**		
Other Healthcare Commission Indicators	Thrombolysis - 60 min call to needle time (cases)	8	1		↔				
	Thrombolysis - 60 min call to needle time (%)	68%	50%	n/a					
	Data Quality on Ethnic Group	95%	#REF!		↑			3	3
	Emergency Bed Days	Reduction	-5.0%		↓			3	3
	Infant Health Data Completeness	85%	99.2%		↑			3	3
	Participation in Audits **	90%	100.0%		↔			3	3
	Waiting times for diagnostic tests (less than 6 weeks)	99.5%	84.4%					1	3
							Existing Targets	25	27
							New Targets	20	25

*-Cancelled Operations rebooked within 28 days - Data relates April 07 to Dec 07

**- Participation in Audits- Data relates to May 07

Note: There are six Healthcare Commission targets which will have a special data collection at year-end

Members' Council Membership Development & Communication Sub-Committee, 29 January 2008

DRAFT MINUTES

Present:

Council Members:	Martin Rowell (MR) Alison Delamare (AD) Chris Birch (CB) Jane King (JK) Cathy James (CJ) Sue Smith (SS)
Trust Members:	Cathy Mooney, Director of Governance and Corporate Affairs (Chair) Julie Cooper (JC), Foundation Trust Secretary/Head of Corporate Governance Matt Akid (MA), Head of Communications Jane Collier (JCo), Equality and Diversity Manager

1. Apologies and welcome:
No apologies were received.

2. Minutes of Sub-Committee meeting held on 23 October
The minutes were agreed as an accurate record of the meeting.

THE MINUTES WERE APPROVED

3. Matters arising from the Sub-Committee meeting held on 23 October 2007

The annual members' meeting is on the agenda.

The Equality and Diversity Assessment of Membership is on the agenda.

JC has made a list of actions being undertaken by volunteers to promote membership and she will circulate to all members.

JC now keeps a register of all proposed constitutional changes.

JC brought a list of membership engagement ideas to the full Members' Council for discussion and prioritisation.

JC sent an email with the phlebotomy query to the manager of the department but she has not yet received a response.

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Action: JC to benchmark realistic increases to membership with other comparable Foundation Trusts.
Action: JC to consider staff categories

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Action: Reformat membership report and categories - JC

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The issue of existing user groups within the Trust was raised. It was suggested that the members of these groups could be encouraged to become trust members if they were not already. We could also target existing community groups both for membership and engagement. JC said that Irfan would have a list of these and the meetings that are held

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Other ideas on the list were discussed and it was felt that they were in progress or not a priority at the moment. JC would update the list and include in the action tracker.

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Action: Run pilot membership surgeries through summer starting at Open Day and promote in April Trust news – JC/MA
Action: Explore having a stand at the Kensington and Chelsea Open Day - JC

Action: Ensure that all participants in Trust user groups are all members and that we are engaging with them - JC
Action: Take the top 'engagement' ideas to the Members Council e.g. 'Mini Medical Series' for members - JC
Action: Merge engagement data into Membership Development action tracker- JC
Action: Get list of community health groups - JC

9. Equality and Diversity Impact Assessment

JCo circulated the equality and diversity assessment template and explained that this needed to be applied to the Membership Development and Communications strategy to discern whether it is fit for purpose. She suggested that the group considers it in preparation for an assessment which would be undertaken at the next meeting. It was agreed to circulate the latest version of the strategy.

JCo said that she will be running equality and diversity training sessions and she encouraged Council Members to attend.

Action: Apply equality and diversity template to portion of the strategy - ALL
Action: Re-circulate Membership Strategy - JC

10. FT Website

MA asked for feedback on the updated site. CB said he likes the overall site now but that he remained concerned about out of date information. He said it seemed that we need to have a clear administrator for the various sections of the site.

11. AOB
CM outlined a process for implementing the opt out option. The group agreed that a month would be the appropriate length of time to allow staff to consider opting out and that several options should be made available ie a return slip, an e mail address and a telephone number. It was suggested that JMTUC was informed. It was suggested that a letter from the chairman could be circulated with pay slips although a small number of staff do not get pay slips. Bank staff were noted. AD said she would continue to encourage membership amongst contracted out staff, who were not employees of Chelsea and Westminster.

MR noted that the recent press coverage regarding the settlement for Lesley Ash had caused concern as some people thought that the trust had had to pay the £5m compensation and were concerned regarding the trust finances.

12. Date of Next Meeting

15th April 4pm TBC

Members' Council Meeting, 14 February 2008

AGENDA ITEM NO.	2.4/Feb/08
PAPER	Membership: Recruitment, Engagement and Sub Committee Highlights
AUTHOR	Julie Cooper, FT Secretary/Head of Corporate Governance
LEAD	Chris Edwards, Chairman
SUMMARY	This paper includes a report on the latest membership numbers, a progress update on membership engagement and the draft minutes from the last Membership Development and Communications Sub Committee meeting from which the Chairman of the Committee will draw highlights.
DECISION/ ACTION	The Members' Council is asked to note the report and offer further ideas for increasing our membership as well as engaging with our membership. The Council is asked to take a decision on the proposed mailing to increase our public membership with consideration for the associated expenditure such a mailing would incur.

1.0 MEMBERSHIP REPORT

1.1 Current Membership Numbers Against Recruitment Targets

OVERALL MEMBERSHIP OVERVIEW	Last Year	This Year 07/08 Target	Current Situation 31 Jan 08
As at start (April 1st 2006)	10,740	13,287	
New Members	5,162	2,809	523
Members leaving or changing constituency	-2,615	-1,958	-695
TOTAL	**13,287**	**14,138**	**13,115**
PUBLIC MEMBERSHIP OVERVIEW	**Last Year**	**This Year 07/08 Target**	**Current Situation 31 Jan 08**
As at start (April 1st 2006)	3,500	6,982	
New Members	4,192	837	113
Members leaving or changing constituency	-710	-698	522
TOTAL (at year end March 31)	**6,982**	**7,121**	**6,573**
PATIENT MEMBERSHIP	**Last Year**	**This Year 07/08 Target**	**Current Situation 31 Jan 08**
As at start (April 1st 2006)	6,536	5,898	
New Members	969	1,769	297
Members leaving or changing constituency	-1,607	-1,179	-105
TOTAL(at year end March 31)	**5,898**	**6,488**	**6,090**
STAFF MEMBERSHIP	**Last Year**	**This Year 07/08 Target**	**Current Situation 31 Jan 08**
As at start (April 1st 2006)	704	407	
New Members	1	203	113
Members leaving or changing constituency	-298	-81	-68
TOTAL(at year end March 31)	**407**	**529**	**452**

1.2 Membership Commentary

The overall membership size has decreased since last year. The drop is mainly due to a decrease in public members, which is the hardest category in which to recruit. There is an increase in both the patient constituency and staff constituency and the membership recruitment drive for staff at the end of last year has proven successful.

The Members' Council voted to move to an 'opt-out' system for staff going forward. The decision must now be put to the full membership of the staff constituency. If the majority of staff members agree with this change it will lead to a substantial increase in our overall membership. However, we will need to focus our attention and resources towards the public constituency.

The best way to increase our public membership is by the use of a mailing. This would entail a letter to approximately 50,000 people within the four boroughs, informing them of the progress the Trust has made to date and inviting them to become members. We feel now would be an opportune time to do this mailing as we need to demonstrate that we are taking steps to increase our public membership and we could also use the fact that the national NHS discount scheme will now include all members of Foundation Trusts. We can assume that other trusts will use this announcement to try and recruit new members. The cost of such a mailing is approximately £50,000 including VAT and postage. There is no provision in the current budget for this mailing, and funds would need to be identified.

1.3 Building and Maintaining a Representative Membership

At present, we are only required to report the percentages of our total membership in terms of ethnicity, sex and age. We want to go a step further and make this data more meaningful so that we can begin to analyse how representative our membership is in comparison to the respective population base. Jane Collier, the Equality and Diversity Manager, will be working with the Membership Development and Communications Sub Committee to undertake an equality impact assessment on the Membership and Communication Strategy, which will enable us to amend the strategy to both increase membership and ensure its diversity as well as help with identifying the necessary resources.

2.0 Membership Engagement: Prioritisation and Progress

The Membership Development and Communications Sub Committee discussed the following ideas and opportunities for engagement. The proposed actions have now been prioritised and the proposed action has been noted under each item:

- **Annual Open Event: Showcase, interactive stands, behind the scenes tours**
  An Open Day will be held again this year on 10 May. Various activities have been proposed and discussed and they are included in the paper on the open day.

- **Annual Members' Meeting: Setup Members Steering Group**
  Last year we convened a steering group to agree key objectives and themes for the Open Day – the group met once and then an implementation group of staff from around the hospital, as well as representatives of the Charity and other charities associated with the Trust, took forward detailed planning and implementation of the Open Day

  This model worked well and we are setting up a steering group meeting once again. We would invite one or more representatives from the Members' Council to sit on this group. A range of dates and times are being proposed for both the week commencing Monday February 18 and the week commencing Monday February 25. We will inform you all of the proposed dates in the near future.

- ***Medicine for Members*** **Talk series on infection control, pain management, palliative care, stroke, diabetes, nutrition.**
  Council Members like the idea of holding a series of lectures on topics of interest to members. It was agreed that these talks could be promoted within the respective clinics. It has been proposed that we advertise the talks in the April Membership mailing with the first talk taking place on the Open Day, followed by one in July and one at the AGM.

- **Membership Surgeries**
  Council Members like the idea of holding Member Surgeries. They feel it is important to be available for members at designated times and places for them to raise concerns. It has been proposed that we advertise the surgeries in the April membership mailing with the first surgery taking place on the Open Day, followed by surgeries in July and then again at the AGM.

- **Member Research Panel**
  This is being set up by Julie Reed and the Research team.

- **Service Reviews**
  Jane Collier, our Equality and Diversity Manager, is to advise further on when we need to consult. We already involve the Members' Council in business planning and the possibility of surveying the full membership on future plans will be explored further in the future.

- **Set up 'Access and Information' group to look at signage and patient access**
  It is believed that we already have an access and information group. Julie has also conducted patient walk abouts to access accessibility and signage.

- **Ad Hoc Lobbying Efforts**
  The Members' Council is kept informed of all external developments which may affect the Trust. Where and when appropriate the full membership can be engaged in lobbying efforts.

- **Conduct Membership Surveys on Key Topics**
  We already involve the Members' Council in business planning and the possibility of surveying the full membership on various topics or service developments will be explored further in the future.

- **Quarterly Members' Council Meetings: Members personally invited**
  It was decided that this would not be necessary as an open invite is already produced in the Members' edition of Trust News.

3.0 Members' Council Membership Development & Communication Sub-Committee, 29 January 2008

DRAFT MINUTES

Present:

Council Members:	Martin Rowell (MR) Alison Delamare (AD) Chris Birch (CB) Jane King (JK) Cathy James (CJ) Sue Smith (SS)
Trust Members:	Cathy Mooney, Director of Governance and Corporate Affairs (Chair) Julie Cooper (JC), Foundation Trust Secretary/Head of Corporate Governance Matt Akid (MA), Head of Communications Jane Collier (JCo), Equality and Diversity Manager

1. Apologies and welcome:
No apologies were received.

2. Minutes of Sub-Committee meeting held on 23 October
The minutes were agreed as an accurate record of the meeting.

THE MINUTES WERE APPROVED

3. Matters arising from the Sub-Committee meeting held on 23 October 2007

The annual members' meeting is on the agenda.

The Equality and Diversity Assessment of Membership is on the agenda.

JC has made a list of actions being undertaken by volunteers to promote membership and she will circulate to all members.

JC now keeps a register of all proposed constitutional changes.

JC brought a list of membership engagement ideas to the full Members' Council for discussion and prioritisation.

JC sent an email with the phlebotomy query to the manager of the department but she has not yet received a response.

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12. Date of Next Meeting

15th April 4pm TBC

Members' Council Meeting, 14 February 2008

AGENDA ITEM NO.	2.7 /Feb/08
PAPER	Healthcare Commission Standards for Better Health Assurance
AUTHOR	Catherine Mooney, Director of Governance and Corporate Affairs
LEAD	Catherine Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	Attached is the draft commentary that has been prepared mainly following an afternoon session with members of the Members' Council and lead directors for the various standards. Further comments have been included following discussion with a member of the Council who was unable to attend the session.
DECISION/ ACTION	The Members' Council is asked to agree the commentary and provide any further comments on the Trust's achievement of the Healthcare Standards.

Members' Council Commentary on the

Standards for Better Health 2007/2008

1. Introduction

The attached is a draft commentary that has been prepared mainly following an afternoon session with members of the Members' Council and lead directors for the various standards. Further comments have been included following discussion with a member of the Council who was unable to attend the session.

This draft has been prepared as if it were coming from the Members' Council directly to the Healthcare Commission. Sections in italics will need updating following the Members' Council meeting in February in addition to any further comments.

The Members' Council is asked to agree the commentary and provide any further comments on the trust's achievement of the Healthcare Standards.

2. Background

The objective of the session was to prepare commentary on Chelsea and Westminster achievements against the core standards for review and approval by the full Members' Council.

It commenced with a presentation from a representative of the Healthcare Commission to set the scene in terms of where the standards fit into the broader Annual Health check. She also demonstrated how the Healthcare Commission assess the results and discussed what was considered 'good commentaries'. (See attached)

Each director introduced their relevant standards and gave a brief background on the Trust approach in that area. Council Members then asked questions and challenged directors on various points, in addition to sharing anecdotal evidence and supporting information relevant to one or more of the standards.

The domains covered in the session were as follows:

- Safety
- Clinical and Cost Effectiveness
- Governance
- Patient Focus

Within these domains, some standards were discussed in detail. This commentary is based on this discussion and the comments received directly as described above.

3. Draft Commentary

Safety

C1a - Healthcare organisations protect patients through systems that:
identify and learn from all patient safety incidents and other reportable incidents and make improvements in practice based on local and national experience and information derived from the analysis of incidents

The Members' Council are assured that all serious incidents are reported monthly to the Board and that they continued to be reported until the Board is satisfied that all actions are implemented. The Members Council have been informed of some specific examples of actions taken as a result of two major incidents and that the Risk Management Committee also followed each incident in detail and tracked progress. Overall assurance for management of clinical risk is through the Clinical Governance Assurance Committee. We understand that the Trust also holds four clinical governance half days per year which allows more detailed discussions on key issues such as learning from incidents.

The Members Council raised an issue with the trust regarding pathology and the fact that they did not always seem to receive information on incidents in a timely manner. We have been informed that a procedure had been developed recently to try and improve mutual exchange of information and that the Trust will look into the specific incident highlighted.

The Members' Council is confident that the process for reporting patient safety incidents and learning from them is robust.

C4 Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that:

a) the risk of healthcare acquired infection to patients is reduced with particular emphasis on high standards of hygiene and cleanliness, achieving year on year reductions in MRSA

The Members Council are aware that the Trust will breach the target for MRSA, but are assured that this is not because the hospital is not safe. The Trust is meeting all the requirements for good practice but in addition is looking at more detail at the different types of patients coming into the hospital, and looking at how they can screen and treat patients accordingly.

The Trust has restricted visiting hours and wards do try and limit the number of visitors for any one patient at a given time.

There is liaison group with the PCT which the Trust believes is very helpful in tackling community acquired MRSA. Enormous efforts are being made around hand hygiene and that the Trust is now coming up to its 4th year of running 'Hand Hygiene Awareness week'.

The Members' Council understands the actions being undertaken and is assured that the Trust is following best practice to minimise the risk of healthcare acquired infections to patients.

b) all risks associated with the acquisition and use of medical devices are minimised

The Members Council believes that Health and Safety policies are excellent and the policy for sharps is well understood. Disposal and waste has improved immeasurably. The Trust is piloting retractable needles. The Members' Council is assured that the risk associated with medical devices, particularly needles, is being minimised.

c) all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed

The Members Council' have been assured that the Trust is fully compliant with decontamination standards.

d) medicines are handled safely and securely

The Members' Council have been informed that the robot in pharmacy has significantly reduced errors and also freed up pharmacists' time to spend on wards.

The long wait in pharmacy was noted. It was suggested that less busy times were publicised to allow those with the option of coming back at a different time to do so.

e) the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment

We suggest that staff should be made more aware of the cost of waste and this might improve the use of the waste bags.

DOMAIN (2) – CLINICAL AND COST EFFECTIVENESS
C5 Healthcare organisations ensure that they

a) conform to NICE technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care
b) clinical care and treatment are carried out under supervision and leadership
a) clinicians continuously update skills and techniques relevant to their clinical work
a) clinicians participate in regular clinical audit and reviews of clinical services

The Members' Council are assured that there is a process for managing NICE technology appraisals and that all trainees and consultants undergo regular training. Professional societies oversee all mandatory training and are increasing the emphasis on standards and audit. The Members' Council have been informed that there is a programme of audits, some mandatory and some voluntary, and that they are very much a part of ensuring quality of patient care. An example of innovation in the care of patients is the 'virtual clinic' model used in sexual health, which is about to go national.

C6Healthcare organisations cooperate with each other and social care organisations to ensure that patient's individual needs are properly managed and met

The Members Council are informed that Service Level Agreements are in place with all key care organisations and the Trust is working on an electronic unified single assessment tool with the local PCT. The Members Council are encouraged by the Trust's views that the Members' Council may have a role in developing relationships with other organisations. The Members' Council was assured that efforts are being made to strengthen links with external organisations and care providers.

DOMAIN- GOVERNANCE
C8 Healthcare organisations support their staff through
b) The healthcare organisation has arrangements in place to ensure that staff know how to raise concerns, and are supported in so doing, in accordance with The Public Disclosure Act 1998: Whistle blowing in the NHS (HSC 1999/198).

The Members Council confirmed that this standard refers to staff being able to raise concerns over bullying, amongst other things. The Council has been assured that dedicated, trained harassment officers were in place and were being approached.

C9 Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose

it was collected for and disposes of the information appropriately when no longer required

The Members' Council have been assured that patient information is being protected and handled correctly. Information governance is addressed by a self assessment process against the Information Governance Tool Kit and the Trust achieved 85% last year, which was validated by internal audit. The Trust needs to make it clearer to staff when records should no longer be held. *Further information on security will be provided to the Members Council in February and this section may be further updated. The Members' Council is assured that the Trust has a systematic approach to records management and that the necessary actions are being undertaken to address the heightened level of concern over data protection.*

C11 Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare
a) are appropriately recruited, trained and qualified for the work they undertake
b) participate in mandatory training
c) participate in further professional and occupational development commensurate with their work throughout their working lives

The Members' Council suggested that delivery of mandatory training might be considered to be done in a different way.

C12 Healthcare organisations which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied

The Members Council is assured that there are systems in place to support research governance. There had been an inspection from the Medicines and Healthcare Regulatory Authority and action plans were in place to address the concerns raised, none of which was serious.

DOMAIN – PATIENT FOCUS
C13 Healthcare organisations have systems in place to ensure that
b) staff treat patients, their relatives and carers with dignity and respect
c) staff treat patient information confidentially, except where authorised by legislation to the contrary
d) appropriate consent is obtained when required for all contacts with patients and for the use of any confidential patient information

The Members Council is assured that the Trust appreciates that patients are most likely to recommend a hospital where privacy and dignity are respected and every effort is made by staff to do so.

C14 Healthcare organisations have systems in place to ensure that patients, their relatives and carers have suitable and accessible information about, and clear access to procedures to register formal complaints and feedback on the quality of services

The Members' Council was assured that the current system of comment/complaint cards was working well and that these cards were available on every ward. PALS staff are available from 9:00-5:00 Monday through Friday to assist patients in filling out forms or accessing patient information. The Members Council have been informed that numerous user groups exist throughout the Trust and focus groups with patients are run on a regular basis within the directorates. The Members' Council is happy with the current system to ensure that patients and relatives get the information they require and that the channels to make a complaint or provide information are available.

C15 Where food is provided healthcare organisations have systems in place to ensure that
a) patients are provided with a choice and that it is prepared safely and provides a balanced diet
c) patients individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day

The Members' Council was assured that fluid and food intake is monitored and informed that the Voluntary Service Manager has been working to train up volunteers to help patients with feeding. There is a team of specialist nutritionists on staff. *The Members Council would like reassurance on the use of 'blue trays'*

C16 Healthcare organisations make information available to patients and the public on their services, provide patients with suitable accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during their treatment, care and aftercare

In response to concerns about aftercare the Members' Council have been informed that a new system to track patient care was being piloted and that arrangements for aftercare is part of the discharge planning process. The Members Council was assured that an action plan was being developed as a result of the Healthcare Commission review into maternity services, and are reassured as to the safety of services provided e.g. the Trust has excellent results for perinatal mortality. The Trust will continue to work with other agencies to improve community care.

C18 Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably

The Members Council are unclear about the issue of equal access to care and the ability of being able to choose Chelsea and Westminster for various treatments. The Members council is aware of one example of a patient being refused treatment (physiotherapy) at Chelsea and Westminster due to the area in which she lived and this is apparently related to what services are commissioned by the PCT.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 14th February 2008

AGENDA ITEM NO.	2.7/Feb/08
PAPER	Open Day 2008
AUTHOR	Matt Akid, Head of Communications
LEAD	Professor Chris Edwards, Chairman
EXECUTIVE SUMMARY	This paper outlines proposed aims and themes of the Trust Open Day 2008 and seeks the active involvement of Members' Council representatives in planning and implementing the event.
DECISION/ ACTION	The Members' Council is asked to comment on the aims and themes suggested for the Open Day, and Members' Council representatives are invited to nominate themselves to sit on the Open Day Steering Group and/or Operational Group.

Trust Open Day 2008

1. Introduction

1.1 Since 1995 Chelsea and Westminster Hospital has held 8 Open Days. Last year's Open Day on Saturday May 12 2007 was the most successful yet. It attracted almost 1,400 visitors, many of whom were Foundation Trust members invited personally through a communication in April 2007 including a letter from the Trust Chairman and a membership newsletter. See the appendix 'Open Day 2007 – Evaluation Report' for full details.

1.2 **Open Day 2008** will be held on **Saturday May 10**. It is an opportunity for the Trust to place itself at the heart of its community by opening its doors to local people and giving them a chance to become more involved in their local hospital. It also enables Trust staff and their families to enjoy a family day.

1.3 In the context of Patient Choice, Open Day is also an opportunity for the Trust to market itself to a range of audiences.

1.4 Open Day 2007 included a Kids' Zone incorporating a Teddy Bear Hospital run by medical students from Imperial College, a charity raffle, tours of specific departments, health advice and information, music, and information stands run by Trust teams, our partners from local NHS and other public sector organisations, and charities associated with Chelsea and Westminster.

1.5 Open Day 2007, and previous Open Days, were funded by a one-off grant from the Chelsea and Westminster Health Charity – this year the Trust applied for a grant of £10,000 and the Charity has approved a grant of £6,000. Therefore the Trust must explore sponsorship opportunities.

1.6 Members' Council activity at Open Day 2008 and possible themes for this year's event were discussed at the Membership Development & Communication Sub-Committee on January 29.

2. Aims and themes

Open Day 2008 should:

- **Market the Trust to Foundation Trust members and local residents** – this will be the Trust's first major public event since achieving a double 'Excellent' rating in the Healthcare Commission's 2007 annual performance ratings which puts us in the top 3 London hospitals and among the top 5% of NHS trusts nationally. Actively marketing the Trust as a provider of choice is a necessity in the context of Patient Choice and competition from other providers including Imperial College Healthcare NHS Trust.

- **Raise the profile of Chelsea and Westminster Health Charity (event supporters)** – in particular the health benefits of their support of the London Duathlon, the benefits to NHS maternity patients of the Private Maternity Unit redevelopment, and the Charity's financial support for projects that support clinical care such as the pharmacy robot and the CT Scanner Appeal.

- **Promote health and wellbeing** – in support of the direction of travel of national government policy and *Healthcare for London: Consulting the Capital* as well as the 'healthy lifestyle' message of the London Duathlon sponsored by Chelsea and Westminster Health Charity.

- **Address issues of public concern** – in particular, infection control, cleaning and hospital food which are all 'big issues' in terms of public opinion about the reputation of the NHS.

- **Foster partnership working** – make the Open Day a 'one NHS' event with active involvement from Chelsea and Westminster Health Charity, other charities associated with the Trust, local NHS, academic and other public sector organisations. This aspect of the day worked well in 2007.

- **Improve staff morale** - involve a wide range of staff and volunteers in a 'feelgood' event that makes us all feel positive and proud to work at Chelsea and Westminster, and gives staff an opportunity to 'show off' the hospital to family and friends.

- **Celebrate the 60th anniversary of the NHS** – 2008 is the 60th anniversary of the NHS and so a public event to mark the history of the 5 hospitals that pre-dated Chelsea and Westminster will be a fitting celebration.

- **Develop communication between Members' Council representatives and Foundation Trust members** – enable Members' Council representatives to meet members and discuss their feedback about the Trust at members' 'surgeries'.

3. Actions for decision by Members' Council

3.1 The Members' Council is invited to comment on the aims and themes of Open Day 2008 outlined above, following initial discussions at the Membership Development & Communication Sub-Committee on January 29.

3.2 The Council is also invited to agree proposed Members' Council activity at Open Day 2008 – potentially to include members' 'surgeries'.

3.3 Members' Council representatives are invited to nominate themselves to sit on the Open Day Steering Group and/or Operational Group:

- **Steering Group** – to provide high level oversight of the Open Day project and to agree overarching objectives for the day. Membership to include the Chief Executives of the Trust and Chelsea and Westminster Health Charity, a Non-Executive Director of the Trust and a representative of the Members' Council.

- **Operational Group** – to manage planning and implementation of the Open Day, once the Steering Group has agreed overarching objectives for the day. Membership to include the Fundraising Director of the Charity, a representative of the Members' Council, as well as representatives of Trust charities, directorates and departments in the Trust, and contractors including ISS Mediclean. Group to be chaired by the Trust's Director of Governance & Corporate Affairs, line manager of the Head of Communications who has overall responsibility for project managing the Open Day.

Matt Akid
Head of Communications
February 2008

Members Council Meeting, 14th February 2008

AGENDA ITEM NO.	3.1/Jan/08
PAPER	Finance Report – 9 months to December 2007
AUTHOR	Lorraine Bewes, Executive Director of Finance
LEAD	Lorraine Bewes, Executive Director of Finance
EXECUTIVE SUMMARY	The Trust continues to report a healthy financial position with a surplus of nearly £10m at Month 9. This is nearly £5m ahead of plan. The Trust is forecasting to achieve a full year surplus of £8.7m which is £3.1m better than plan. An assessment of all known financial risks has been included in this forecast. The Trust is on track to retain its excellent rating for use of resources rating under the annual health check by the Healthcare Commission. Cash balances at the end of December stand at £31.3m which is £8.6m ahead of the Monitor plan. This surplus against plan is driven by the cumulative I&E surplus together with slippage on capital spend and an improvement in working capital.
DECISION/ ACTION	The Members' Council is asked to note the financial position at Month 9.

Financial Summary to December 2007

1. Introduction

1.1. This paper presents the financial position for the nine months to the end of December 2007. The key points set out in the table below are that the Trust has achieved a surplus of £10m as at Month 9 and the forecast outturn is projected to be a surplus of £8.7m.

	Year to 31st December 2007				Forecast			
	Budget £'m	Actual £'m	Variance £'m	% Var	Budget £'m	Actual £'m	Variance £'m	%Var
Income	192.0	192.3	0.3	0.2%	256.9	256.8	-0.1	0.0%
Expenditure	174.2	170.6	3.6	2.1%	234.6	232.2	2.3	1.0%
EBITDA	17.8	21.7	4.0		22.4	24.6	2.2	
EDITDA Margin %	9.2%	11.3%			8.7%	9.6%		
Interest, Dividends and Depreciation	12.6	11.7	0.8		16.8	15.9	0.9	
Surplus/Deficit (-ve)	5.2	10.0	4.8		5.5	8.7	3.1	
Surplus Margin %	2.7%	5.2%			2.2%	3.4%		
ROA %					4.5%	6.0%		
Liquidity (days)	37.6	54.9			37.6	53.1		
Risk Rating		5			4	5		

2. Summary Financial Position at Month 9

2.1. The income and expenditure position to the end of December represents a £4.8m favourable variance against plan, with an in-month favourable variance of £0.62m.

2.2. The forecast outturn position for the Trust has improved by £0.78m to a surplus of £8.7m, a favourable variance of £3.1m. The pay forecast has improved due to an improved outlook for Directorate savings plans, together with higher than anticipated savings on nursing and medical pay budgets as a result of closures over Christmas. The non-pay forecast has deteriorated due to a continuing pressure on non-pay budgets particularly in the Surgical specialties. The income forecast has improved this month due to a reassessment of the risk relating to over performance on non elective activity. However the forecast still includes a provision of £0.5m for a potential penalty for non achievement of the 18 weeks target. The key points underpinning the forecast are explained in section 2.6.

2.3. The Earnings before Interest, Tax, Depreciation and Amortisation or EBITDA margin remains ahead of plan at 11.3% for the year to month 9, compared to a planned EBITDA margin of 9.2%. The Trust's financial risk rating at month 9 continues to be a "5" in line with Month 8. The overall rating for the Trust for the year is forecast to be a 5 rather than a 4 subject to the Trust remaining on plan to achieve the forecast £3.1m surplus at 31st March 2008.

2.4. The key issues that are driving the position at Month 9 are as follows:

2.4.1. Income under performed against budget in month by £1.34m, due to the fact that there was a 10% reduction in spells during December compared to the average of the previous eight months. This under performance is directly related to the reduction in elective activity due to the number of public holidays in the month.

2.4.2. The pay position has improved by £0.86m in December, which again relates to the closure of elective theatres and beds over Christmas. In addition to this there has continued to be significant slippage on planned pay developments currently funded in Reserves.

2.4.3. The non pay position has improved by £0.95m in month. The majority of this movement is due to a £0.7m under spend on HIV drugs due again to Christmas closures.

2.5. The year to date savings plan of £6.1m is £0.24m (4%) ahead of plan at Month 9, which is in line with the position as at Month 8. The Trust is now forecasting to deliver £9.0m of savings against the £8.45m savings plan by year end, which represents an overachievement against target of £0.55m.

2.6. The Trust forecast at Month 9 has improved to a surplus of £8.7m at year-end, which represents a forecast surplus of 3.4% of total income. The key factors behind the projected deterioration in the surplus between Month 9 and the year-end are as follows:

2.6.1. The income forecast makes provision for the maximum £0.5m penalty that PCTs could levy if the Trust fails to meet the 18 week target by 31st March 2008. This penalty would only become payable once the activity data for March had been reviewed by PCTs and it would depend on the extent to which the Trust had not achieved the target.

2.6.2. The expenditure forecast makes provision for additional consultancy costs during the last 3 months of the year to support the Trust's bid to become the Specialist Paediatrics centre within the NW sector, together with additional support costs for Clinical Coding, R&D and Financial Planning / Service Line Reporting.

2.6.3. The HIV drugs forecast assumes that the saving on HIV drugs in December will be mitigated by increased spend in the final three months of the year, i.e. that those patients who were not seen in December will be added to the cohort of patients seen during January and February.

3. Delivery of 18 Weeks

3.1. The Trust set aside a total of £2.6m in the opening reserves for 07-08 to meet the cost of delivering the 18 week target based on 50% marginal costs within the national tariffs. Subsequently a further £0.4m was added to recognise that extra costs may be needed to bring the total provision to £3.0m.

3.2. During the period to the end of Month 9 £0.98m has been distributed to Directorates in recognition of the excess costs of delivering 18 weeks, and the Directorate forecasts estimate that a further £0.7m will be required to meet the target. Total funding to Directorates for delivery of 18 weeks in the year is therefore expected to be £1.67m, leaving a balance of £1.39m.

3.3. In order to secure the 18 week target, the Trust is currently negotiating with the private sector to provide capacity for up to 350 procedures to be carried out mainly by the Trust's consultants in the private hospitals where they have admitting rights. The negotiations are complex involving the private sector providers, the hospital consultants and the patients and it is not possible at this stage to determine the precise cost of exporting this level of activity. In many cases, the exact procedure and therefore cost will not be known until the procedure has been completed. The cost of a relatively small number of procedures has been negotiated and agreement has been reached with one provider for the procedures to be performed at tariff rates.

3.4. Based on the latest available information, using agreed rates where negotiated and tariff rates elsewhere, the external costs are estimated at £0.74m. Whilst it is possible that this estimate will increase, there is significant headroom within the balance of the provision made and within the existing forecast outturn.

3.5. The total income assumed in the 07-08 plan for 18 week activity was £4.4m. The income forecast assumes that £1.4m of this income will be generated in the final quarter of the year. This assumption has been validated by a review of the actual patient quantum to be treated in the final quarter, which suggests that the income associated with the activity yet to happen will be in the region of £1.5m (split across patients to be treated in house and those who will be exported to other providers).

4. Risks

4.1. The main financial risks facing the Trust are as follows:

4.1.1. Risk on delivery of the 18 weeks activity within the available funding. The potential fine if the Trust does not meet the 18 week target by 31st March 2008 has been factored into the forecast.

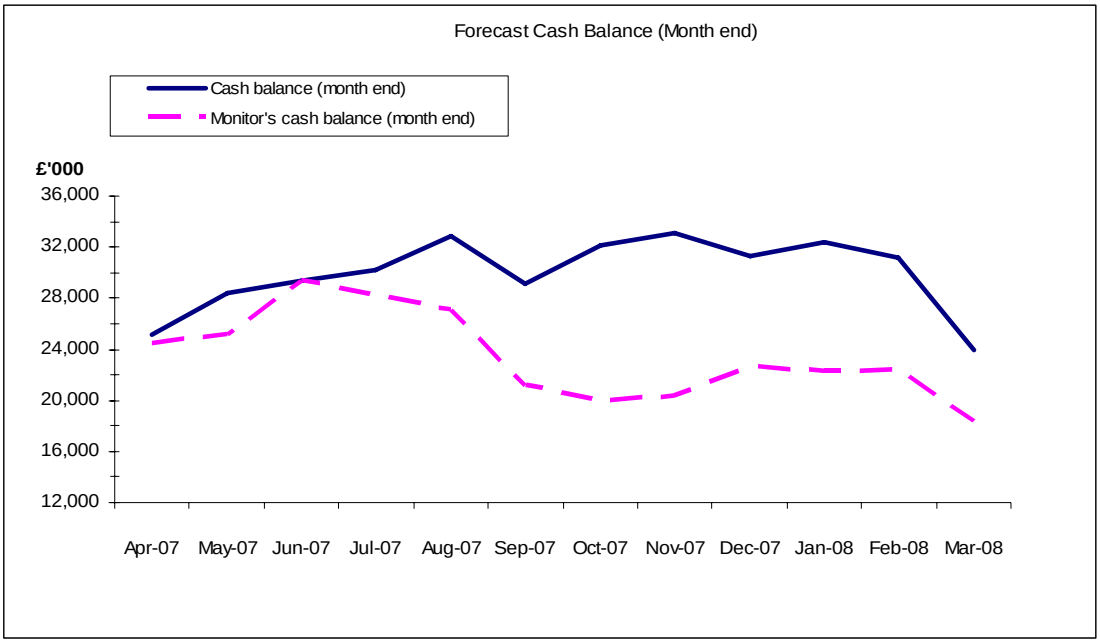
4.1.2. Risk on contract income in view of the current growth in referrals and the likelihood of PCTs agreeing to pay for the additional activity.

5. Cash Position (F9)

5.1. The cash position at the end of December 2007 is ahead of plan with a balance of £31.3m compared to Monitor's plan of £22.7m.

5.2. The receipt of Resource Accounting Budgeting (RAB) surplus of £2.2million from the host PCT for 05-06 received in September 07 has been paid back to the Department of Health in December 07. This was not included in the original plan.

5.3. The cash forecast indicates that the Trust will be on average, for the next 12 months, at least £5.1m ahead of the plan submitted to Monitor in the 2007-08 Annual Plan.



5.4. The returns on the Trust's short term deposits has historically outperformed the cost of financing the Trust loans and in this month records an average interest rate gain of 0.63%.

	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07
	%	%	%	%	%	%	%	%	%
Weighted average investment returns	5.20	5.39	5.53	5.74	6.04	5.86	5.84	5.94	5.67
Weighted average cost of Loans	(5.16)	(5.16)	(5.11)	(5.11)	(5.11)	(5.07)	(5.07)	(5.07)	(5.04)
Average interest rate gains	0.04	0.23	0.42	0.63	0.93	0.79	0.77	0.87	0.63

6. Capital Programme

6.1. The Capital Budget for the year remains the same at £21.5m.

6.2. The expenditure of £4.7m to date is 51% of the expected spend of £9.3m. There are however some high value projects that are still at the procurement stage and expenditure will not be expected on most of these schemes until the final quarter of this financial year. As of December, there are commitments of £4.9m. These include orders which have been raised and contracts signed but for which goods/services have not yet been received.

Glossary of Terms

ACU: Assisted Contraception Unit

AFC: Agenda for Change

Basket procedures: List of procedures deemed by Audit Commission to be day cases

BPPC: Better payment practice code (code for paying suppliers on time)

CHKS Benchmark: External benchmark club

DNA: Do not attend

Downside risk: Things could get worse

EBITDA: Earnings before interest tax depreciation amortisation

ETWD: EU Working Time Directive

Failed day case: planned day surgery where patient is admitted

FT: Foundation Trust

HHNT: Hammersmith Hospitals NHS Trust

I & E: Income and Expenditure

Internal indicators: indicators determined by Board which are over and above the Healthcare Commission and Monitor targets

LAS: London Ambulance Service

MFF: Market forces factor

MPET: Multi-professional education and Training

NICU: Neonatal Intensive Care Unit

PACS: Picture Archiving Communication System e.g. Digital x-ray

PDC Drawdown: Public dividend capital (equity finance vs. loan finance)

SaFF Income: Income under contract from PCT

SLA: Service Level Agreements

PTA: Professional and Technical ..

Ring fenced: Predetermined use for funds

Trolley procedures: List of procedures deemed by Audit Commission to be in-hospital cases

Workforce indicators: Internal indicators regarding staffing

W & C: Women and Children's

Upside Risk: Things could get better