Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting

Hospital Boardroom
Chair: Prof. Sir Christopher Edwards
Date: 18 June 2009
Time: 4:30 – 6:30 pm

Agenda

		Lead	
1	**GENERAL BUSINESS**		
1.1	Welcome & Apologies	CE	
1.2	Declaration of Interests	CE	
1.3	Minutes of Previous Meeting held on 19 March 2009	CE	
1.4	Matters Arising	CE	
1.5	Review of Action Points from Joint Away Day 4 December 2008	CE	
1.6	Chairman's Report (oral)	CE	
2	**ITEMS FOR DISCUSSION/DECISION/APPROVAL**		
2.1	Update on Developments – Major Trauma / Stroke & Paediatrics	CE	
2.2	Members' Council Membership Development & Communications Sub-committee: a) Minutes of the meeting held in May 2009 b) Review of Terms of Reference c) Membership Tracker d) Draft Membership Development & Communications Strategy	MR	
2.3	Experience:		
	a) Patient	AMC	(Presentations)
	b) Staff	MG	(Presentations)
	c) GP	AK	(Presentations)
2.4	Open Day 2009 – Evaluation Report	MAk	
2.5	The Annual Members' Meeting 2009	MAk	
2.6	Membership Report	DH	
2.7	Funding Report	DH	
2.8	Review of Constitution: a) The title of the Members' Council b) Persons exercising functions at the Trust	CE	
2.9	Policy for the composition of the Members' Council and the non-executive directors	CE	

2.10	Nominations Committee: Review of Terms of Reference	CE
2.11	Quality Accounts	CM
2.12	Elections Update	DH
3	**ITEMS FOR INFORMATION**	
3.1	Finance Report – March 2009	LB
3.2	Annual Plan 2009-10	LB
3.3	Monitor's Consultation – Guide for NHS Trust Governors: Meeting your statutory responsibilities	CM
4	**ANY OTHER BUSINESS**	
5	**DATE OF THE NEXT MEETING 17th September 2009 at 3:00pm**	

Annual Performance Appraisal of Chairman

To: The Senior Independent Director

The Members' Council led by its Deputy Chairman, Brian Gazzard, has carefully considered the Chairman's past performance at the Trust from initial appointment on 1st November 2007 to XXXX *(date of Chairman's Statement)*.

The Chairman's performance was considered against pre-determined objectives which support the delivery of the Trust's forward plan. The scope of the appraisal included the evaluation of all relevant performance issues including those relating to the Members' Council; however, the Members' Council has noted that the primary aim of the Chairman's work is leading the Board of Directors.

Any QUALIFICATION or MATTER OF EMPHASIS can be stated here if required.

[Subject to] / [Except for] / [Notwithstanding] those matters mentioned in the above paragraph, The Members' Council confirms that the performance of the Chairman continues to be effective and the Chairman continues to demonstrate commitment to the role.

Brian Gazzard
Deputy Chairman of the Members' Council
On behalf of the Members' Council
18th June 2009

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 18 June 2009

AGENDA ITEM NO.	1.3/Jun/09
PAPER	Minutes of the meeting of the Members' Council held on 19 March 2008
AUTHOR	Dianne Holman, Interim Foundation Trust Secretary/Head of Corporate Governance
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper outlines a record of proceedings at the previous meeting.
DECISION/ ACTION	1. To agree the minutes as a correct record. 2. The chairman to sign the minutes.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council
Public Meeting, 19 March 2009

PRESENT:

Prof. Sir Christopher Edwards	Chairman		CE
Lady Sandra Smith-Gordon	Public	Kensington and Chelsea 2	SSG
Christine Blewett	Public	Hammersmith and Fulham 2	CBle
Mary Symons	Public	Wandsworth 1	MS
Martin John Lewis	Public	Westminster 2	ML
June Bennett	Patient		JB
Walter Balmford	Patient		WB
Jane King	Patient		JK
Martin Rowell	Patient		MR
Jim Smith	Patient		JS
Chris Birch	Patient		CBir
Alison Delamare	Staff	Contracted	AD
Brian Gazzard	Staff	Medical and Dental	BG
Sue P Smith	Staff	Nursing and Midwifery	SPS
Catherine Longworth	Appointed	Westminster PCT	CL
Cllr. Frances Taylor	Appointed	Royal Borough of Kensington and Chelsea	FT
Nicky Browne	Appointed	The Royal Marsden NHS Foundation Trust	NB
Duncan Macrae	Appointed	Royal Brompton and Harefield NHS Trust	DM

APOLOGIES:

Martin Bradford	Public	Hammersmith and Fulham 1	MB
Lionel Foulkes	Public	Wandsworth 2	LF
Ann Mills-Duggan	Public	Westminster 1	AMD
Sue B Smith	Patient		SBS
Peter Molyneux	Appointed	Kensington and Chelsea PCT	PM
Prof. Mervyn Maze	Appointed	Imperial College, London	MM

IN ATTENDANCE:

Charles Wilson	Non-Executive Director	CW
Colin Glass	Non-Executive Director	CG
Heather Lawrence	Chief Executive	HL
Lorraine Bewes	Director of Finance	LB
Andrew MacCallum	Director of Nursing	AMC
Amanda Pritchard	Deputy Chief Executive	AP
Hannah Coffey	Director of Operations	HC
Catherine Mooney	Director Of Governance	CM
Dianne Holman	Interim FT Secretary	DH
Matt Akid	Head of Communications	MAk
Renae McBride	Paediatric Communications	RMB
Steve Francis	Project Management Services	SF
Bill Gordon	IT Department	BGo
Binnie Grant	Stroke Service	BGr
Diana Middleditch	Kensington & Chelsea PCT	DM

The meeting was called to order by the Chairman.

1.1 Apologies

Apologies were tendered by Martin Bradford, Lionel

Foulkes, Ann Mills-Duggan, Sue B Smith, Peter Molyneux and Mervyn Maze.

1.2 Declaration of Interests

The Chairman invited declaration of interests. None were tendered.

1.3 Minutes of Previous Meeting held on 4 December 2008

These were agreed as a correct record of proceedings.

1.4a Joint Away Day 4 December 2008 – Minutes

These were agreed as a correct record of proceedings subject to the following corrections:
Page 1 – Delete duplications for Martin Lewis and Christine Blewett
Page 2 – Change 'AM' to 'AMC'
Include as present Cllr. Frances Taylor and Catherine Longworth.

1.4b Joint Away Day 4 December 2008 – Matters Arising

The meeting discussed the action points and subsequent outcomes.

1) HC introduced SF from Project Management Services who presented drawings to illustrate the two refurbishment options for the area known as the Information Zone. Council members raised concerns about obstruction to the Friends Shop and the PALS area and the arrangement of the kiosks in 2 different areas. SF explained that there would be no obstruction and the arrangement afforded a greater level of privacy around the kiosks. CBir commented that the main problem was that the technology was not working. It was agreed that the advantages of additional expenditure would be discussed later in the Agenda under the Funding Report.

2) AMC reported on an earlier presentation by Computershare and stated that the membership was short of young people. Members suggested that this group could be reached through Facebook, school and youth club visits. It was agreed that the Trust would ask Computershare to make a presentation in the future.

3) AMC also reported that his team was inundated with responses to the Seasonal Working Conference and the turnout was likely to be twice the number originally expected. AMC also

reported on strategies for communicating with the membership including Trust News and Panels.

4) BGo joined the meeting and reported that the IT problems in the Information Zone had been resolved with a more robust software solution. Members held very strong views on this issue and were concerned that their earlier attempts had failed and IT failures could give a very poor impression to prospective members. It was agreed that Bill Gordon should be contacted directly in the future if further failures were reported.

5) HL agreed to a meeting on the long-term vision and strategy for the hospital and a date would be arranged at a more appropriate time when there was greater clarity about the strategy. HL

6) AMC reported on efforts to broaden work around the patient experience and agreed to share the results of the Patients Survey at the next meeting. AMC

7) The roles and responsibilities of the Members' Council would be dealt with later in the agenda.

8) CE reminded the meeting that 'Task & Finish' groups were confined to specific tasks and were not sub-committees and invited suggestions. ML suggested getting more involved in mystery shopping. CE responded that the board of Directors would support this.

The meeting agreed to proceed immediately to item 2.1 in order to facilitate the presentation by Diana Middleditch of Kensington & Chelsea PCT on behalf of Peter Molyneux.

1.5 Matters Arising from meeting on 4th December 2008

Some members commented that there was not adequate notice of the Business Planning workshops.

The Chairman reported on MedMedia Ltd explaining that there were 2 companies with the name and reassured the meeting on the background of the relevant company. CE also reported that the Trust was looking into the possibility of a screen with announcements. Three test sites were proposed.

Members asked if there would be a need to go out to tender; if it would be similar to Patient Line; and if public health messages would be aired. CE said tendering would depend on the value and explained that no costs

were involved to either patients or the Trust as this was a revenue-sharing initiative to raise revenue in the current economic climate.

1.6 Chairman's Report (oral) (Dean Street opening)

The Chairman reported that Lord Darzi was due to open the Dean Street facility at lunch-time on 12th May. Dean Street is a state-of-the-art clinic which in addition to its normal daytime opening hours was also open on two evenings per week and Saturdays.

WB asked about the effect on income and CE responded that the prospects were good due to increased activity. ML asked about advertising to which the Chairman responded that this was currently done by word-of-mouth and that any further promotion risked overwhelming the capacity of the centre. CBir commented that he had visited the facility and was very impressed.

CE also reported that the Trust had written to Imperial College Healthcare Trust to congratulate them on being awarded the status of an Academic Health Sciences Centre.

2.1 Healthcare for London Consultation, Stroke and Major Trauma

Diana Middleditch presented proposals for major trauma and stoke services consultation.

CE expressed the particular concerns of the Chelsea and Westminster Foundation Trust. The Trust had been supportive of the proposal to put the Hyper-Acute Stroke Unit (HASU) at Charing Cross. It had been difficult to decide between Chelsea and Westminster and Charing Cross but the geographical location of Charing Cross and the location of neurosurgery there had been the decisive factors. It was now proposed that if major trauma was at St Mary's that neurosurgery would be moved from Charing Cross to St Mary's and with it the HASU. This completely vitiated the basis of the consultation which was about the location of the HASU at Charing Cross.. DM disagreed that this was the case.

HL asked DM if there were figures to support the affordability of neurosurgery at St. Marys and Charing Cross in an economic downturn. DM said that she had not seen the figures and could not comment. HL emphasised the link between trauma and neurosurgery and questioned the validity of arriving at the preferred option in the absence of such analysis and the availability of capital if St Marys becomes an FT by the expected date of 2014.

NB asked if there would be helipads at each trauma centre to which DM responded that this was not thought to be helpful in terms of time.

JB was concerned about the competency and qualification of paramedics. DM confirmed that the proposal included the training of ambulance crew.

HL considered that the Trust had not been identified as a preferred hyper-acute stroke unit although this part of North West London was not well served.

CE considered that both the arguments of geography and neurosurgery put forward in the proposals were reasonable in the context of the HASU being at Charing Cross but did not apply if the HASU was moved to St Mary's. He stated that while the Trust would support the Charing Cross location, it could not support an uncosted, non-assessed move to St. Marys.

CE also raised concerns about the procedure and questioned the fairness of allowing the public consultation meeting to be held at St. Mary's.

JB proposed that the Members' Council submitted a response to the consultation before the deadline of 8th May. The meeting agreed to this action. **CE**

Cbir asked about representation of the PCTs. DM confirmed that all the PCTs plus Surrey were represented. HL was concerned that Kensington & Chelsea PCT was under-represented as neither the Chairman nor the Chief Executive were appointed as representatives.

In relation to heart attacks, members expressed concerns about the journey time to hospitals.

Members also commented on the workforce issues and the competition that would be created in recruiting the large numbers of staff proposed. CE confirmed that failure to become a hyper-acute stroke unit would adversely impact on the reputation of the Trust and its ability to attract quality staff.

BG commented that the Trust had managed to improve its service and in order to avoid any loss of morale if it is moved, the process should be scrupulously fair and so far it was not clear that this was the case.

CE agreed that this was a very useful opportunity to explore the issues and invited DM to consider the

likelihood of realisation of the proposals in a financial downtown and the opportunity costs. CE thanked DM for the presentation.

DM left and the meeting reverted to the agenda.

2.2 'Support our Stroke Services' campaign

MAk presented a paper on the issues surrounding the consultation questionnaire on the choice of a location for a hyper-acute stroke unit. The meeting questioned the validity of the underlying reasons for C&W not being recommended as the preferred option by HfL.

The meeting agreed to MAk's proposal of a collective response from the Members' Council and further agreed to HL's proposal that it is authored by the Deputy Chairman of the Members' Council, Brian Gazzard.

MAk also urged individual Council Members to respond.

2.3 Paediatrics consultation

HL reported on the paediatric tender and said that it was not yet ready but the Trust was developing its plan to become the designated paediatric centre in North West London. HL said that the Trust would need to demonstrate its ability to provide short term ventilation and develop networks with partners in North West London. HL also informed the group that planning permission was in progress for a two-storey extension of the building at Netherton Grove to facilitate the bid.

CE stressed there was a need for a fair and transparent consultation process.

In response, SSG asked if the meeting could go back to the Major Trauma/ Stroke consultation as it was related to the issue of responses and asked the meeting to confirm that there should be individual responses from Council Members to support 3 centres. The meeting agreed.

For Paediatrics, members asked if they could submit letters in support of the Trust's bid in their individual capacities and it was agreed that there should be both a collective letter of support from the Members' Council as well as letters from individual members who also wanted to respond in this way to both bids, if required. **CE**

2.4 Members' Council Funding Report

CE gave an overview of the allocation of the Members' Council budget including spend to date; further spend to

complete approved activities; and the allocation of recurrent funding. The meeting noted the report. CE invited the meeting to consider the report and submit further ideas for the 2009/10 allocation outside of the meeting. Members drew attention to the need to control overspending in 2009-10.

2.5 Development of the Trust website

MAk presented a paper and discussed proposals for improving the Trust's website following a root and branch diagnostic analysis of site.

HL reported that the Trust's team would be meeting to look at the 5 key suggestions made to optimise the website and to roll out the new visual identity piloted with 56 Dean Street across the whole website. CBir agreed to sit on the Website Development Steering Group.

MAk confirmed that 56Dean.com was in preparation. The Trust had tried to purchase an existing domain but had been unsuccessful. MAk also confirmed that more than 20,000 users accessed the website mostly for maternity and paediatrics and that all four boroughs in the public membership constituencies were in the Top-10 broadband usage.

CE concluded that the diagnostic work sponsored by the Members' Council was good value for money.

2.6 Open Day 2009

MAk presented a paper on the proposed aims, themes and the funding model for the Open Day 2009.

CE suggested that the key issue for the Members' Council is to develop relationships and communicate with constituents. The meeting discussed modes of communication with members and the constraints imposed by data protection requirements. The Trust News will say that members can meet their representatives. **The Secretary was asked to look into the mechanism of communication with the Council Members.** **DH**

CBir suggested an overall theme 'Your Hospital, your healthcare, your say' to ask for views. It was agreed that Open Day communications should replace '***our'*** with '***your'*** as is applicable.

The meeting agreed to fund the Open Day 2009; however, SSG felt that this should not necessarily be funded recurrently.

It was agreed that an email would be circulated to invite

nominations to the Steering Group and Operational Group.

The meeting agreed that Boris Johnson should be approached to officially open the event.

2.7 Membership Report

The meeting noted the report and acknowledged the benefit of the discharge leaflets in increasing the numbers in the patients' constituency.

AMC reported that the responsibility for engagement would be moved from the FT Secretary to the new Engagement and Membership post and this was expected to fit in well with the Trust's work around the patients' experience.

The meeting discussed the motivation of members joining the Trust and CE suggested that members could be motivated by a demonstration of openness and pride in what a fantastic place the hospital is and the opportunity for 'ownership' by joining as a member.

JB suggested that members attending the next Annual Members' Meeting should be asked what they would like as members of the hospital.

2.8 Roles and Responsibilities of the Members' Council

The paper was agreed. **ALL**

2.9 Healthcare Commission Standards for Better Health

CM tabled a paper outlining the comments of the Members' Council on the Trust's performance against its declaration of performance on the various elements and standards of Standards for Better Health.

The meeting agreed to the comments subject to the following amendments:
14a: Change 'complain' to 'comment on their care'.
7e: replace 'lack of respect' with more appropriate wording and include the elderly as a group with special needs.

CE thanked the meeting for their comments and invited Council members to continue to send in comments until the end of the following week.

CBle expanded on the context saying that the Members' Council was represented on the Trust's Assurance Committee by CBle and MS. CBle emphasised that the comments should not relate to individual experiences but should ensure that the Trust was aware of any problems.

3.1 Finance Report – Month 10

The meeting noted the paper.

3.2 Performance Report – Month 10

The meeting noted the paper.

3.3 Minutes of the Members' Council Membership Development & Communications Sub-Committee held in February 2009

The meeting noted the paper.

4 Any Other Business

The meeting was directed to the flyers asking for a Council Member to join the local Clinical Excellence Awards Panel 2009. HL explained that the role would be to oversee the process rather than to mark papers.

There being no further business, the meeting was adjourned. The next meeting will be held on 18th June 2009 at 4:30pm.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 18 June 2009

AGENDA ITEM NO.	1.4/Jun/09
PAPER	Matters Arising
AUTHOR	Dianne Holman, Interim Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper lists matters arising from previous meeting(s) and the action taken or subsequent outcomes.
DECISION/ ACTION	The Members' Council is asked to note the matters arising and the updates.

Matters Arising from Previous Meetings

Reference	Item	Lead	Actions or Subsequent Outcomes
2.1/Mar/09	**Healthcare for London Consultation, Stroke and Major Trauma**		
	JB proposed that the Members' Council submitted a response to the consultation before the deadline of 8th May. The meeting agreed to this action.	CE	See2.2/Mar/09 below.
2.2/Mar/09	**'Support our Stroke Services' campaign**		
	The meeting agreed to MAk's proposal of a collective response from the Members' Council and further agreed to HL's proposal that it is authored by the Deputy Chairman of the Members' Council, Brian Gazzard. MAk also urged individual Council Members to respond.	BG	Prof. Sir Christopher Edwards responded to the consultation in the capacity of Chairman of the Board of Directors and Prof. Brian Gazzard responded in his capacity as Deputy Chairman of the Members' Council.
2.3/Mar09	**Paediatrics consultation**		
	For Paediatrics, members asked if they could submit letters in support of the Trust's bid in their individual capacities and it was agreed that there should be both a collective letter of support from the Members' Council as well as letters from individual members who also wanted to respond in this way to both bids, if required.	CE	At the time of writing, it is not yet known if there will be a consultation.

Reference	Item	Lead	Actions or Subsequent Outcomes
2.4/Mar/09	**Members' Council Funding Report**		
	CE invited the meeting to consider the report and submit further ideas for the 2009/10 allocation outside of the meeting.	ALL	Item 2.4 on the Agenda.
2.6/Mar/09	**Open Day 2009**		
	The Secretary was asked to look into the mechanism of communication with the Council Members.	DH	The Trust informs the public via its Annual Report and its website that members who wish to communicate with their representatives on the Members' Council or Executive Directors should contact the Foundation Trust Secretary. A few Council Members' have authorised issuing direct contact details. Names and short biographies of Council Members are posted on the website. Best practice calls for a communication mechanism with the means to provide information over the longer term which adequately supports the role of the Members' Council in inviting contact with the membership, e.g., active targeting and constituency meetings. This discussion of roles could be informed by Monitor's consultation 'Guide for NHS Foundation Trust Governors: meeting your statutory responsibilities'. This is on the agenda for information.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 18 June 2009

AGENDA ITEM NO.	1.5/Jun/09
PAPER	Matters Arising from Joint Away Day held on 4 December 2008
AUTHOR	Dianne Holman, Interim Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	The Board has considered the action points arising from the Joint Away Day and summarised its comments on the next steps.
DECISION/ ACTION	The Members' Council is asked to update and agree actions as appropriate.

Notes on Joint Away Day held on 4 December 2008

Ref	Summary and action points	Lead	Comments
1	Remain focussed on increasing our patient membership. Explore the best ways of using the kiosks and membership area to both engage with existing members and to recruit new ones.	AM/FT Secretary	One kiosk will be moved to outside the PALS area. The refurbishment of the membership area including bench seating and screening the area is complete. The technical problem of failing kiosks has been resolved.
2	CG has agreed to meet with interested Council Members to discuss the best model for constituency meetings. The Council and Board felt it important to discern whether they were going out to 'listen' or to 'lend' information. It was felt a director should attend these meetings as well to answer immediate queries. It was agreed a system of tracking these queries and feeding back was necessary. This system will depend on how this will link in with PALS in future.	AM/CM	Constituent meetings to be taken forward. A system will be developed to track queries raised and subsequent actions. *Computershare* will be invited to a Members' Council meeting to raise awareness of benchmark performance and actual penetration into the different geographic, demographic and psychographic segments of membership constituencies. This will also inform the analysis on funding requirements for recruitment which will be taken forward by the Members' Council Membership Development & Communications Sub-Committee. ***A new Membership & Engagement Manager has been appointed to start in July 2009. These initiatives will be taken forward when this person is in post. An annual plan of work and engagement will be agreed with the Members' Council.***

Ref	Summary and action points	Leads	Comments
3	Develop a set of specific proposals to support communications looking at how to take engagement forward and on how best to communicate with our respective constituents	AM	There were a number of noteworthy initiatives for engagement and communication: The Spring Seasonal Working Conference to which members will be invited; the Engagement & Membership post which was about to be advertised; special members' edition of the Trust News; quarterly staff and patient panels; and more effective data-mining of the membership database. ***These will be incorporated into the Plan described above.***
4	Hold a dedicated meeting with the Council on the long term vision and strategy for the hospital.	HL	***This has been set for the afternoon session of Friday 11th September. Council Members' are asked to let Heather's PA know if they can attend.*** ***Email: Louise.Starkey@chelwest.nhs.uk*** ***Phone: 0208 846 6711***
5	Produce a report for MC overviewing the themes coming from PALS and Complaints to direct their activity and focus	AM	CE suggested that the focus should be the patients' experience which was an important component of quality, which will include complaints and PALS but will be wider. ***This is on the Agenda.***
6	The Board is to come back with a clear proposal of what they would like from both the membership and the Council	Trust Board	***The updated roles and responsibilities have been agreed. See also update for Item 7.***

Ref	Summary and action points	Leads	Comments
7	Create more task and finish groups to increased focus involvement	CE	A number of ideas for 'Task & Finish' groups were suggested. The Board also explored existing representation in local networks and the opportunities for further involvement in Local Area Agreements and Local Strategic Partnerships. The Board also acknowledged the use of mystery shopping. ***It is proposed that a Task & Finish Group is set up to respond to the Monitor Consultation 'Guide for NHS foundation trust governors: meeting your statutory responsibilities'. Please contact Dianne Holman if interested in joining this group.*** ***The Members' Council is asked to suggest any other Task & Finish Groups.***

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Quarterly Meeting
18 June 2009

AGENDA ITEM NO.	2.10/May/09
PAPER	Nominations Committee: Review of Terms of Reference
AUTHOR	Dianne Holman, Interim FT Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper proposes updated Terms of Reference for the Nominations Committee of the Members' Council for the appointment of Non-Executive Directors. The original Terms of Reference at Appendix 1 contained random extracts from the Constitution on the topic of appointments and did not focus on the work of the Committee. The proposed draft Terms of Reference has been streamlined and refreshed to include the provisions of current version of the constitution and to adopt the standardised form for the Terms of Reference used by all Committees and working groups of the Trust. Apart from the role assigned in the Constitution, it is proposed that the Nominations Committee will also be tasked with reviewing the Members' Council Policy for the Composition of Non-Executive Directors. The meeting's attention is drawn to the final sentence of paragraph 3.1. This is a requirement of the Constitution at section 12.5.4 but it is felt that the independent assessor should not be the Chairman of another FT. Any amendments would require approval of a majority of members voting at a members' meeting and the independent regulator, Monitor.

DECISION / ACTION	The meeting is asked to: a. Consider whether or not the requirement for an independent assessor should be restricted to the Chairman of another FT. b. Approve the Terms of Reference subject to the decision at (a.) above.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TERMS OF REFERENCE OF

THE NOMINATIONS COMMITTEE

OF THE MEMBERS' COUNCIL

FOR THE APPOINTMENT OF NON-EXECUTIVE DIRECTORS

DRAFT

1.0 Authority

1.1 The Nominations Committee is a Standing Committee of the Members' Council which facilitates the Members' Council in appointing non-executive directors. Its terms of reference shall be as set out below and shall not be amended, revoked or replaced except by a resolution passed at a meeting of the Members' Council.

2.0 Roles

The Nominations Committee shall:

2.1 Identify appropriate candidates (not more than five for each vacancy) through a process of open competition which takes account of the policy maintained by the Members' Council and the skills and experience identified by the Board of Directors.

2.2 Make recommendations for the successful candidate to the Members' Council.

2.3 Review the policy for the size, structure and composition of the non-executive directors which takes account of relevant Trust strategies from time to time and not less than every three years and make recommendations to the Members' Council.

3.0 Membership

3.1 The Nominations Committee will comprise the Chairman of the Foundation Trust (or the Vice Chairman unless they are standing for appointment, in which case another non-executive director, when a Chairman is being appointed), two elected Council Members and one Appointed Council Member. The chairman of another Foundation Trust will be invited to act as an independent assessor to the Nominations Committee.

4.0 Attendance

4.1 The Director of Human Resources will attend the committee to provide advice and secretarial services to assist the committee.

5.0 Meetings

5.1 The Nominations Committee shall meet on occasions when necessary as determined by the Chairman.

5.2 A quorum shall be three Council Members including the Chairman (or the Vice Chairman of the Board of Directors when a Chairman is being appointed).

5.3 The Nominations Committee will report to the Members' Council after each meeting.

6.0 Review

6.1 The terms of reference of the committee shall be reviewed by the Members' Council at least bi-annually.

Fleur Hansen
Foundation Trust Lead
24th January 2007

DRAFT REVISED DH June 2009

Appendix 1

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TERMS OF REFERENCE FOR NOMINATIONS COMMITTEE AND PROCESS FOR APPOINTMENTS

1.0 Nominations Committee

1.1 The Nominations Committee will comprise the Chairman of the Foundation Trust (or the Vice Chairman unless they are standing for appointment, in which case another non-executive director, when a Chairman is being appointed), two elected Council Members and one Appointed Council Member. The chairman of another Foundation Trust will be invited to act as an independent assessor to the Nominations Committee.

2.0 Roles and Responsibilities of Members' Council Regarding Appointments

2.1 The roles and responsibilities of the Members' Council, which are to be carried out in accordance with this constitution and the Foundation Trust's authorisation, are:

2.2 at a General Meeting:

2.1.1 to appoint or remove the Chairman and the other non-executive Directors;

2.1.2 to approve an appointment (by the non-executive Directors) of the chief executive;

2.1.3 to decide the remuneration and allowances, and the other terms and conditions of office, of the non-executive Directors;

2.1.4 to appoint or remove the Foundation Trust's financial auditor;

2.1.5 to appoint or remove any other external auditor appointed to review and publish a report on any other aspect of the Foundation Trust's affairs;

2.1.6 to be presented with the annual accounts, any report of the financial auditor on them and the annual report;

2.2 to prepare and from time to time review the Foundation Trust's membership strategy and its policy for the composition of the Members' Council and of the non-executive Directors.

3.0 Board Appointments Process

3.1 The following Board of Directors appointments need to be ratified by the Members' Council:

3.1.1 the Chairman, who is to be appointed (and removed) by the Members' Council at a General Meeting;

3.1.2 five other non-executive Directors who are to be appointed (and removed) by the Members' Council at a General Meeting;

3.1.3 in each case subject to the approval of a majority of the Members' Council (in the case of an appointment) present and voting at the meeting, and three-quarters of all of the members of the Members' Council (in the case of a removal) voting at the meeting;

3.1.4 a Chief Executive (who is the accounting officer), who is to be appointed (and removed) by the non-executive Directors, and whose appointment is subject to the approval of a majority of the members of the Members' Council present and voting at a General Meeting;

3.2 Non-executive Directors are to be appointed by the Members' Council using the following procedure:

3.2.1 The Members' Council will maintain a policy for the composition of the non-executive Directors which takes account of the membership strategy, and which they shall review from time to time and not less than every three years.

3.2.2 The Board of Directors will work with an external organisation recognised as expert at appointments to identify the skills and experience required for non-executive Directors.

3.2.3 Appropriate candidates (not more than five for each vacancy) will be identified by a Nominations Committee through a process of open competition, which take account of the policy maintained by the Members' Council and the skills and experience required;

3.3 The removal of the Chairman or another non-executive Director shall be in accordance with the following procedures:

3.3.1 Any proposal for removal must be proposed by a Council Member and seconded by not less than ten Council Members including at least two elected Council Members and two appointed Council Members.

3.3.2 Written reasons for the proposal shall be provided to the non-executive Director in question, who shall be given the opportunity to respond to such reasons.

3.3.3 In making any decision to remove a non-executive Director, the Members' Council shall take into account the annual appraisal carried out by the Chairman.

3.3.4 If any proposal to remove a non-executive Director is not approved at a meeting of the Members' Council, no further proposal can be put forward to remove such non-executive Director based upon the same reasons within 12 months of the meeting.

Fleur Hansen
Foundation Trust Lead
24th January 2007

MEMBERS' COUNCIL
18th June, 2009

AGENDA ITEM N°	2.11/Jun/09
PAPER	Quality Reports
LEAD	Mike Anderson, Medical Director
AUTHOR	Catherine Mooney, Director of Governance and Corporate Affairs
SUMMARY	This paper outlines the requirement from Monitor regarding quality reports as part of the annual report for 2008-09. There is also a similar requirement in the annual plan. The quality report for the Trust for 2009-10 is attached.
ACTION	The Members' Council is asked to note the report and to comment on the content and in particular the priorities selected.

1. Introduction

This paper introduces quality accounts and the requirements from Monitor for the annual reports for 2008-09. There is a similar requirement in the annual plan for 2009/10.

Quality was defined by Lord Darzi in 'High Quality Care for all' as having three components; patient safety, clinical effectiveness and patient experience.

2. Background

If legislation is approved, the publication of quality accounts will be required for all trusts from 2010 onwards. Following the publication of 'High Quality Care for all' in 2008 a reporting framework has been developed by the Department of Health, Monitor, the Care quality Commission and NHS East of England.

Following a consultation on including quality accounts in this year's annual report Monitor has published the following:

3. Monitor Requirements for the Annual Report

The requirements are as in the attached quality report and include a quality narrative, three priorities for quality improvement and why they have been selected, and what is planned to achieve improvement.

Monitor states that the aim in requiring the inclusion of improvement priorities is to encourage boards to set explicit improvement goals and discuss these openly with the public. Understanding why these issues have been selected will provide greater insight into the performance of the trust and its approach to quality improvement. How trusts select their priorities is likely to be of interest to local stakeholders and boards should consider how best to engage on this issue.

The reports should also contain a section on a response to any reports from regulators in relation to the quality of care offered by the trust and to concerns raised by bodies representing the public. Monitor also suggests that 'Boards will wish to consider how they want to use the quality report to reflect more broadly the views of local communities, patients and service users in relation to the quality of the services on offer. Accurately reflecting and addressing such concerns will provide a real demonstration of public accountability'.

There is also an overview of the quality of care offered by the Trust against indicators selected by the Trust which must include at least 3 indicators for patient safety; at least 3 indicators for clinical effectiveness; and at least 3 indicators for patient experience.

Finally there is a section on performance against the key national priorities from the Department of Health's Operating Framework and against the Department of Health's National Core Standards.

4. Trust Response

Monitor consulted on the inclusion of the quality reports in the annual report for 08/09 (and 09/10 annual plan) as it will not be a legal requirement until 2010/11. Despite concerns raised by the Foundation Trust Network including timing and the ability to seek views in such a short timescale, Monitor issued their final guidance in May on the annual reports to include this requirement. This meant that Trusts were under considerable pressure to identify and agree priorities, and involvement with the public and other stakeholders was not possible.

However, the Board carefully considered the quality improvement proposals put forward by the executive team, and the reasons why these were selected and agreed the three priorities, with the

view that some of these were already part of the corporate objectives and all were both challenging and of significant benefit to patients.

5. Members' Council Input

The Members' Council is asked for their views on the priorities selected. Quality improvement can be seen as a journey that has no end point, there is always more than can be done and every report is therefore an interim report. It is important that key stakeholders are involved, both in setting priorities and in help with delivery e.g. members will be involved in the Patient Panels used to gain feedback on our services.

Quality Report

Lesley-Anne Marke, Sister on David Erskine Ward, with patient Josephine Sinclair

Introduction

The Trust Board is committed to providing quality care for all patients and to quality improvement.

This commitment to quality underpins our 3 corporate objectives for 2009/10:

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

We welcome the fact that this year for the first time Monitor, the independent regulator of Foundation Trusts, requires all Foundation Trusts to publish a Quality Report.

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

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

- Chelsea and Westminster was named as one of the safest hospitals in the country by the Dr Foster Hospital Guide in November 2008—it highlighted us in the top 20% of NHS trusts nationally with significantly lower than expected Hospital Standardised Mortality Ratios (HSMRs)

- The Trust achieved NHS Litigation Authority risk management standards at Level 2 following an assessment visit in December 2008—we passed 48 out of 50 criteria in 5 areas of risk management

- We have reduced our MRSA bacteraemia rate by 90% in the last 5 years and in 2008/09 we significantly outperformed both targets for the reduction of both MRSA bacteraemia and *Clostridium difficile*

We are proud of these achievements and we are committed to improving quality further—our 3 priorities for quality improvement in 2009/10 are outlined in this Quality Report.

Other quality objectives include:

- Reviewing the detailed data behind the overall HSMR statistics to ensure that we reduce avoidable mortality

- Building on our success in achieving NHS Litigation Authority risk management standards at Level 2 by ensuring that processes are embedded in the Trust and that systems set up to monitor compliance are effective in delivering further improvements in safety for patients and staff

- Maintaining our focus on best practice in infection prevention and control to drive down healthcare associated infections still further

- Ensuring that directorates identify clinical quality indicators at specialty level, monitor performance against these indicators, and report on this performance—in line with the Indicators for Quality Improvement published by the NHS Information Centre in May 2009

- Improving our performance against the patient experience indicators in the annual NHS patient survey through more frequent monitoring—including 'real-time' patient feedback using an electronic Patient Experience Tracker and the formation of a Patients' Panel to be used as a sounding board by the Trust

We are committed to ensuring that a culture of continuous quality improvement is embedded in the Trust and we will work closely with all our staff to make addressing these issues a priority in 2009/10 and beyond.

Heather Lawrence

Heather Lawrence
Chief Executive

Quality narrative

Priorities for quality improvement 2009/10

The Trust Board has agreed that the Trust's top 3 priorities for quality improvement in 2009/10 should be:

Priority 1: Patient safety

To reduce our preventable venous thromboembolism (VTE) rate by 15% in the next year.

Why is this a priority?

VTE is a major cause of preventable death and reducing its incidence is a national priority for the NHS.

It is estimated that in England each year more than 25,000 people die from VTE contracted in hospital and 1 in 3 patients undergoing surgery in hospital can develop VTE if no preventative measures are taken.

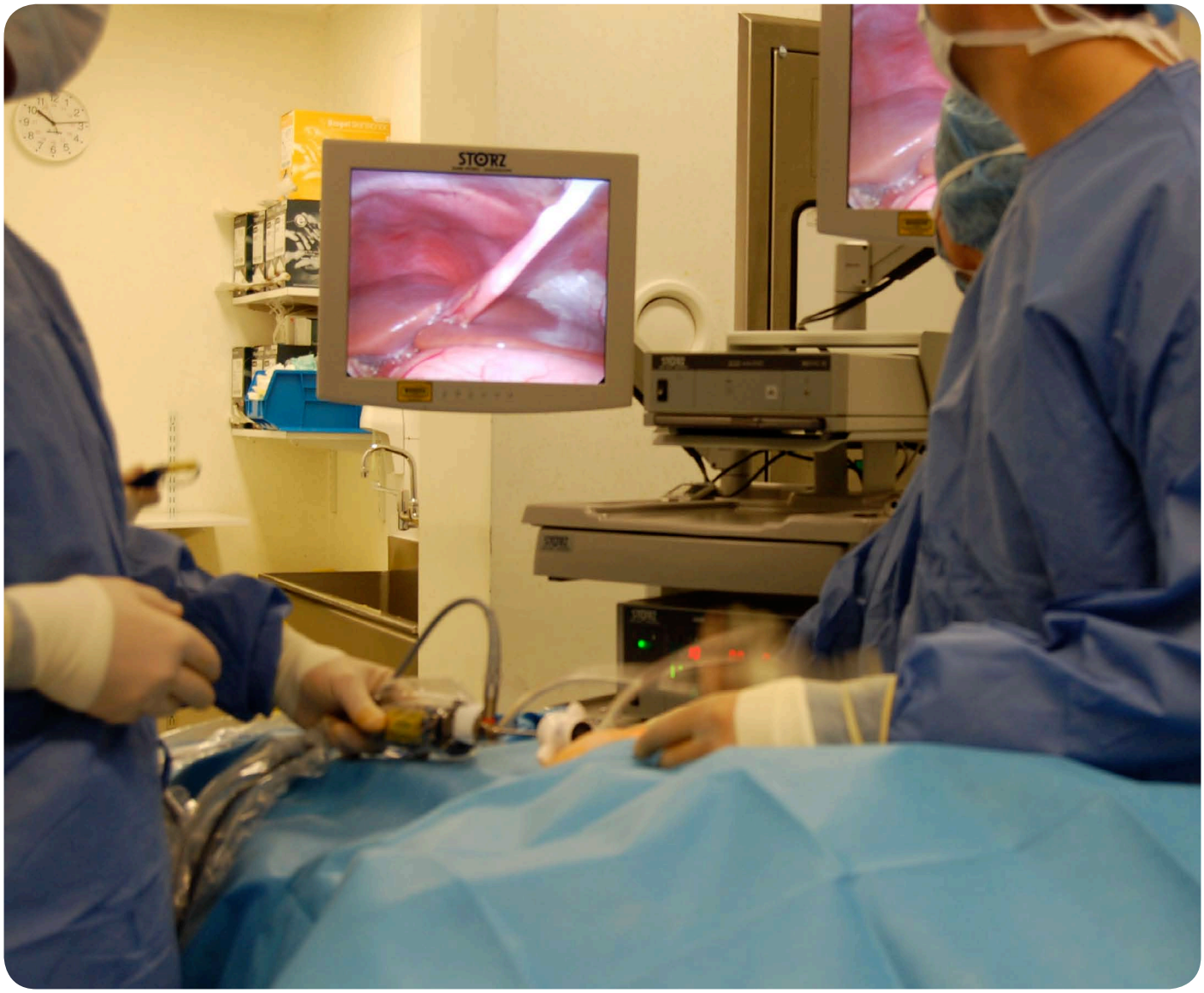
In addition, non-fatal VTE can require treatment with anticoagulant drugs at doses with a significant risk of bleeding, causes delays in patients' discharge home from hospital, and often results in readmissions to hospital.

What actions are we planning to improve our performance?

The Trust has established a multi-disciplinary committee to oversee implementation of the recommendations of the Chief Medical Officer's expert working group on the prevention of VTE in hospitalised patients, implementation of National Institute for Health and Clinical Excellence (NICE) guidance, and adherence to Trust guidelines on VTE prevention including the use of an electronic risk assessment tool and audit of prescribing.

How will improvement be measured?

Rates of hospital acquired VTE will be measured with the aim of reducing preventable VTE by 15% in the first year.



Priority 2: Patient experience

Ensure that 90% of women have an 'Excellent' experience of our maternity services.

Why is this a priority?

High quality maternity services are vital to the success of the Trust's overall strategy as a centre of excellence in women's and children's health. Most women have a positive experience of maternity services at Chelsea and Westminster, as evidenced by the fact that 86% of women who took part in the Healthcare Commission's maternity review 2008 rated their care as 'Excellent', 'Very good' or 'Good'.

However, there are known areas for improvement as a result of feedback from incidents and complaints and the Trust wants to ensure that all women have a positive experience of our maternity services.

What actions are we planning to improve our performance?

The Trust's maternity services were chosen as a pilot site for a patient experience project developed by Monitor, the independent regulator of Foundation Trusts, and McKinsey in 2008/09 to understand our patients and act on their concerns. In 2009/10 we will look to implement fully the recommendations from this project and embed a culture of continuous patient feedback and improvement in our maternity services.

The Trust focused considerable resources on improving maternity services during 2008/09 through the Monitor/McKinsey project and its own Maternity Services Improvement Review. This focus will continue in 2009/10.

How will improvement be measured?

'Real-time' patient feedback monitoring tools, in particular the Patient Experience Tracker, will be used to measure and track improvements.

Priority 3: Clinical effectiveness

To reduce delays of more than 24 hours to selected non-elective urgent surgery.

Why is this a priority?

Senior Trust surgeons have expressed concerns that a number of factors may be exacerbating delays for some patients requiring non-elective urgent surgery.

These factors include a drive to meet the national 18 week target from GP referral to treatment, increased numbers of patients requiring surgery, and implementation of National Confidential Enquiry into Patient Outcome & Death (NCEPOD) guidelines restricting out-of-hours operating unless life is at stake.

The Trust is responding directly to these concerns by making the reduction of delays to selected non-elective urgent operations a priority for quality improvement in 2009/10.

This work will complement existing initiatives to improve the effectiveness and efficiency of the use of operating theatres.

What actions are we planning to improve our performance?

Each surgical speciality is reviewing arrangements for non-elective urgent operating. Initiatives include the appointment of a dedicated consultant emergency surgeon for general surgery, appointment of a trauma nurse to focus on improving the pathway for patients with fractured neck of femur, and a review of the plastic surgery trauma service including the 'hand room' and dedicated hand trauma theatre.

In addition, a theatre improvement group has been established which will include a focus on creating clear leadership and efficient management of non-elective surgery.

How will improvement be measured?

Time to operation from decision to operate will be measured to establish a baseline for each selected surgical procedure. Individual targets will be set with the aim of a progressive improvement towards a target of 100% of non-elective urgent surgery being undertaken within 24 hours.

Response to reports from regulators & concerns raised by organisations representing the public 2008/09

Annual performance ratings

The Trust met all national targets in the annual performance ratings 2008 with a single exception, resulting in a reduction of our 'Quality of Services' rating from 'Excellent' in 2007 to 'Good' in 2008.

This was due to the fact that the Trust did not fully meet a national target relating to the Choose and Book system after uncovering a technical fault during the pilot stage which may have compromised patient confidentiality.

The Trust therefore 'failed' this target by delaying the rollout of Choose and Book to other specialties until September 2007.

We believe it was right to put the best interests of patients above the requirements of meeting a target. On average 85–90% of our services are now directly bookable via Choose and Book.

Kensington & Chelsea Residents' Panel

In February 2009 the Royal Borough of Kensington & Chelsea published the results of the healthcare section of its 2009 Residents' Panel questionnaire.

A total of 440 local residents took part in the survey, of whom 53% had visited their local hospital as a patient in the previous year—of these respondents, 61% had visited Chelsea and Westminster Hospital.

Residents rated us more highly than other local hospitals on 5 key questions:

- 73% agreed that the person they were referred to had all the information about their condition
- 82% said they were treated with dignity and respect
- 85% agreed information they were given was easy to understand
- 59% said standards of hygiene were adequate
- 73% would recommend the hospital to friends and family

The Trust is encouraged by these results. However, we are concerned about the dissonance between these results and annual NHS patient survey results. The Trust will use the Patient Experience Tracker to test out patient views and help improve its performance further.

Quality overview

Indicators selected to measure the Trust's performance

The Trust Board has chosen 9 indicators to measure performance:

Patient safety

1. Reduce our preventable venous thromboembolism (VTE) rate by 15% in the next year (Data source: Internal Trust data and national Dr Foster data).
2. Reduce in-hospital cardiac arrest and mortality through earlier recognition and treatment of the deteriorating patient (Data source: Internal Trust data in line with measures recommended by the national Patient Safety First Initiative).
3. Reduce the risk of selected high risk medicines (Data source: Internal Trust data in line with measures recommended by the national Patient Safety First Initiative).

Patient experience

4. Ensure that 90% of women have an 'Excellent' experience of our maternity services (Data source: Internal Trust data and Healthcare Commission [now the Care Quality Commission] maternity patients survey).
5. Achieve a progressive improvement in key issues identified in the annual NHS patients survey relating to communication, information and customer service (Data source: Healthcare Commission [now the Care Quality Commission] annual NHS patients survey).
6. Reduce the number of complaints relating to appointments and admissions (Data source: Internal Trust data).

Clinical effectiveness

7. Reduce delays of more than 24 hours to selected non-elective urgent surgery (Data source: Internal Trust data).
8. Reduce Hospital Standardised Mortality Ratio (HSMR) by 10% (Data source: National Dr Foster data).
9. Reduce the number of urinary catheter days, ie the number of days that patients in the Trust have a urinary catheter—excluding patients who require lifelong urinary catheters (Data source: Internal Trust data).

Performance against regulatory requirements and national targets

Regulatory requirements

The Trust declared full compliance to the Healthcare Commission (now the Care Quality Commission) with all 24 core standards contained within Standards for Better Health for 2008/09—with 1 exception.

This exception was standard 13c ('Healthcare organisations have systems in place to ensure that staff treat patient information confidentially, except where authorised by legislation to the contrary').

The Trust had a significant lapse against this standard during 2008/09 but achieved full compliance by the end of the financial year. See page 35 for full details.

National targets

(excluding cancer waiting time targets)

Requirement/target	2008/09 performance	Target
Incidence of Clostridium difficile	**41**	114
Incidence of MRSA bacteraemia	**5**	19
18-week maximum waiting time from point of referral to treatment (admitted patients—inpatients)	**92.07%**	90%
18-week maximum waiting time from point of referral to treatment (non-admitted patients—outpatients)	**98.29%**	95%
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	**98.75%**	98%
People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack)	**n/a**	n/a

Cancer waiting time targets

1 Apr–31 Dec 2008 (Q1–Q3)

Requirement/target	Performance	Target
Maximum waiting time of 2 weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	**99.7%**	98%
Maximum waiting time of 31 days from decision to treat to start of first definitive treatment for cancer	**100%**	98%
Maximum waiting time of 62 days from all referrals to first definitive treatment for cancer	**100%**	95%

Cancer waiting time targets

1 Jan–31 Mar 2009 (Q4)

Requirement/target	Performance	Target
Maximum waiting time of 2 weeks from receipt of urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	**97.3%**	93%
Maximum waiting time of 31 days from decision to treat to start of first definitive treatment for all cancers (admitted and non-admitted)	**95.7%**	97%
Maximum waiting time of 31 days from decision to treat to start of subsequent treatment or recurrence (surgery and drug therapy)	**100%**	97%
Maximum waiting time of 62 days from all referrals to first definitive treatment for all cancers	**100%**	85%
Maximum waiting time of 62 days from date patient is upgraded by consultant onto urgent cancer pathway	**100%**	85%
Maximum waiting time of 62 days from all referrals received by national screening programme (breast, bowel, cervical)	**100%**	85%

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Choose Chelsea and Westminster

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 18 June 2009

AGENDA ITEM NO.	2.12/June/09
PAPER	Election Update
AUTHOR	Dianne Holman, Interim FT Secretary
LEAD	Dianne Holman, Interim FT Secretary
EXECUTIVE SUMMARY	This report provides details of planned timetable for election to the Members Council in Autumn 2009 and the list of vacancies and candidates retiring on 30th September 2009.
DECISION / ACTION	The meeting is invited to review the election plan.

Timetable

The timetable is structured to meet statutory requirements and also to capitalise on the publicity generated by the Annual Members' Meeting on 17th September and the preceding recruitment week to enlist nominations and secure a satisfactory voter turnout.

Publication of notice of election	Not later than the fortieth day before the day of the close of the poll	Friday	28 August 2009
Final day for delivery of nomination papers to returning officer	Not later than the twenty eighth day before the day of the close of the poll	Tuesday	15 September 2009
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll	Wednesday	16 September 2009
Members' Council Meeting & Annual Members' Meeting		Thursday	17 September 2009
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll	Friday	18 September 2009
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll	Friday	02 October 2009
Close of the poll	By 5.00pm on the final day of the election	Friday	23 October 2009
Announcement of results		Tuesday	27 October 2009
Induction			November 2009
Next Members' Council Meeting		Thursday	03 December 2009

Current vacancies and vacancies arising on three-year term ending 30th September 2009

Status	Start Date of Office	Category	Constituency	First Name	Last Name
Filled	21/03/2006	Patient	(blank)	Hugo	Fitzgerald
				Jim	Smith
				Maria Elena	Arana
				Martin	Rowell
				Michael	Henry
		Public	Hammersmith and Fulham 2	Christine	Blewett
			Wandsworth 2	Lionel	Foulkes
		Staff	Contracted	Alison	Delamare
			Medical and Dental	Brian	Gazzard
			Support, Administrative and Clerical	Cathy	James
	21/03/2006 Total				
	01/10/2006	Patient	(blank)	Jane	King
	01/10/2006 Total				
Vacant	No valid nomination forms received to deadline 23/10/07	Staff	Management	(blank)	(blank)
	No valid nomination forms received to deadline 23/10/07 Total				
	04/05/2007	Staff	Allied Health Professionals, Scientific and Technical	Nathan	Billing
	04/05/2007 Total				
	05/12/2007	Public	Kensington and Chelsea 1	(blank)	(blank)
	05/12/2007 Total				
	(blank) Total				
Grand Total					

Members' Council Meeting, 18 June 2009

AGENDA ITEM NO.	2.1a/Jun/09
PAPER	Report on Major Trauma and Stroke
AUTHOR	Fleur Hansen, Business Planning & Strategic Adviser
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This report outlines key issues for the attention of the Members' Council
DECISION/ ACTION	The Members' Council is asked to note the report.

Report on Stroke and Major Trauma

Healthcare for London (HfL) and North West London PCTs have been active in designating specialist services over the past year with the Trust submitting bids for three services.

Major Trauma
HfL is also reviewing major trauma services in London at the centre of which will be specialist major trauma centres (MTC), one of which will provide major trauma cover for North West London. Although the Trust has not bid to become a MTC, it would function as a trauma centre as part of the network and work with the designated MTC. The results of the public consultation are expected at the same time as stroke services.

Stroke
The public consultation was run from late January until early May with HfL putting forward a recommendation that Chelsea and Westminster be designated for SU and TIA services but not to become a HASU. HfL's recommendation was that Charing Cross Hospital, part of Imperial College Healthcare NHS Trust (ICHT) is the location for the HASU in our local area which we supported. However, we do have an issue with the way the consultation has been undertaken as the consultation indicated that if St Mary's Hospital (also part of ICHT) were to be designated as a major trauma centre, then the HASU would likely be co-located with major trauma at St Mary's. We believe if this were to happen, then it would call into question the reasons why the HASU was recommended to be located at Charing Cross, namely because it is co-located with neurosurgery and its geographical location. Placing a HASU at St Mary's would result in two HASUs being within one mile of each other (the other being UCLH) and may result in longer travel times for west London patients.

Prof. Sir Christopher Edwards responded to the consultation in the capacity of Chairman of the Board of Directors and Prof. Brian Gazzard responded in his capacity as Deputy Chairman of the Members' Council.

The London-wide consultation on improving stroke and major trauma has now closed. The joint committee of primary care trusts (JCPCT) will consider the responses to the consultation and announce the decision in July 2009.

Members' Council Meeting, 18 June 2009

AGENDA ITEM NO.	2.1b/Jun/09
PAPER	Report on Improving Surgical Services for Children and Young People in Hospital
AUTHOR	Heather Lawrence, Chief Executive
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This report outlines key issues for the attention of the Members' Council
DECISION/ ACTION	The Members' Council is asked to note the report and discuss any key issues that arise.

Report on Improving Surgical Services for Children and Young People in Hospital

At the meeting held in public on 12 May 20096, the NWL JCPCT accepted the recommendations made by the Project group that Chelsea and Westminster Hospital NHS Foundation Trust become the preferred provider of specialist surgical and neonatal surgery.

The NHS London Executive Meeting held on 18 May 2009 accepted this recommendation. The next stage is for the Overview and Scrutiny Committees to consider whether the change is substantial and requires formal consultation. Informal feedback suggests that may not be necessary as we already carry out a significant amount of this work and it therefore does not constitute a significant change. If this is agreed, the formal 'Preferred Provider Selection' occurs. It is at this stage that we will need to begin mobilisation for the contract change due to commence in the next financial year.

The Trust will need to further develop the proposed 'federated model' with our partners, particularly, Guys and St. Thomas NHS Foundation Trust and Great Ormond Street Hospital. We will need to set up an initial network meeting and proceed with the appointment of a Network Director to take this forward. I have invited the Project Board Lead and NHS Harrow CEO, Dr. Sarah Crowther, to join the Mobilisation group.

The decision has been well received by staff in the hospital at large and by many of our partners. The successful bid was made possible by strong clinician and management relationships, innovation around communication with children and our stakeholder engagement. The team was noted to be non-hierarchical, inclusive, demanding but fun. It is a tribute to our staff that the scores were as follows:

Table 1: Overall Scores

Workstream	**Criteria**	**Chelsea & Westminster %**	**Imperial %**
1. Service Specification	A – Provision of Care	11.13	8.51
	B – Strategic Fit	12.06	9.14
	C – Governance	5.35	4.76
	D – Quality of Care	9.45	7.2
	E – Focus on Child and Family	8.7	5.71
	F – Workforce for the Provision of Surgical Services	4.37	3.45
	G – Facilities	3.38	2.66
	H – Physical Access	1.17	0.88
	J – Networks	10.91	8.84
TOTAL (out of 90%)		66.52	51.16

Table 1: Overall Scores (continued)

Workstream	Criteria	Chelsea & Westminster %	Imperial %
2. Commercial and Legal	A – Financial Proposals	2.13	1.57
	B – Pricing and Performance Monitoring	2.21	1.94
	C – transitional Arrangements	2.87	1.80
	D - Legal	N/A	N/A
Total (out of 10%)		7.20	5.27
GRAND TOTAL (out of 100%)		73.72	56.46

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Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 18 June 2009

AGENDA ITEM NO.	2.2a/Jun/09
PAPER	Draft Minutes of the Meeting of the Members' Council Sub-Committee for Membership Development & Communications
AUTHOR	Cathy Mooney, Director of Governance and Corporate Affairs
LEAD	Martin Rowell, Patient Member, Chairman
EXECUTIVE SUMMARY	This paper outlines key issues discussed at the meeting of the Members Council Membership Development and Communications Sub-Committee meeting
DECISION/ ACTION	For information. The minutes will be approved at the next meeting of the sub-committee on 25th August 2009.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

DRAFT
Members' Council Meeting, Membership Development and Communications Sub-Committee Minutes, 19th May 2009

Present:

Council Members:	Martin Rowell (MR), Chairman Chris Birch (CB), Patient Jim Smith (JS), Patient June Bennett (JB), Patient Jane King (JK), Patient Alison Delamare (AD), Staff – Contracted
Trust members:	Cathy Mooney (CM), Director of Governance and Corporate Affairs
In Attendance:	Jane Tippett (JT), Assistant Director of Nursing Claire Kennedy (CK), Communications Manager Alex Prior (AP), GP Liaison Manager

1. Apologies

Apologies for absence were received from:
Andrew MacCallum (AM), Director of Nursing
Matt Akid (MA), Head of Communications
Dianne Holman (DH), Foundation Trust Secretary/Head of Corporate Affairs

2. Minutes of the Previous Meeting Held 24 Feb 2009

The minutes were approved with the following amendments:

Andrew MacCallum to be AM or AMC, consistent throughout the document.
P2 5/Nov/08 Membership Strategy: Information Zone to replace Membership Area.
P4 Section 9 'opt out' to replace 'opt put' in the last paragraph.
P6 second sentence: AM to be replaced by CM.

3. Matters arising

3.1 Matters Arising (5/Nov/08)
The tracker is on the agenda. The record of the number of kiosk users is not available. CM to follow up.

3.2 Matters Arising (6/Nov/08)
CM has sent notes from the last Annual Members' Meeting to MA.

3.3 Matters Arising (7/Nov/08)
Update as reported in the Matters Arising document. There are 1818 for email only communication and 1172 for post/email. If these are mutually exclusive, that gives a total of 2990 members with email addresses or 24% of public and patient membership.
Action: to continue to promote email as a means of communication.

3.4 Matters Arising (8/Nov/08)
To review Terms of Reference
On agenda at item 4.

3.5 Matters Arising (4/Feb/09)

DH has discussed this with the Computershare. The service can be done at approx £10-15 per member targeted. With a recovery rate of 7% the recruitment cost will be between £143 and £214 per member recruited. The meeting expressed concern at the cost and wanted clarification on exactly what this meant. CM thought this meant addresses of members where mail had been returned could be followed up to find out where they have moved to.
Action: CM to clarify.
Post-meeting note: It does refer to follow up as described by CM.

3.6 Matters Arising (4/Feb/09)
To provide the list of email addresses for a membership database. DH has reported that this can be retrieved via the database for campaigns (at a cost). CM to clarify what this means.
Action: CM to clarify.

3.7 Matters Arising (6/Feb/09)
To include the Seasonal Conference events mailing as a one-off. This was actioned.

3.8 Matters Arising (8/Feb/09)
To ensure the Information Zone refurbishment is complete. It was noted that the overhead feature was not yet completed.
Post-meeting note: this has now been done as of 24 May 09.

3.9 Matters Arising (8/Feb/09)
The screens malfunctioning have now been resolved.

3.10 Matters Arising (8/Feb/09)
To link LCD screen information with Trust News.
Action: CM to confirm this is in place.

3.11 Matters Arising (9/Feb/09)
Arrangements for staff to be automatically members and opt out is on the agenda.

3.12 Matters Arising (12/Feb/09)
The proposed funding for mailing for MC has been actioned.

3.13 Matters Arising (12/Feb/09)
To circulate Terms of Reference with minutes. Actioned.

JB raised the issue of the duathlon. The meeting was reminded that this is still a Matters arising but would be discussed nearer the time of the duathlon.

4. Review of Terms of Reference

CB expressed concern at the number of Trust members of the Committee and felt it should predominantly be the Members' Council. CM felt that all the members were necessary and needed to be on the Committee for the work of the committee to be done. She pointed out that eventually she would not attend the meeting once AM had taken on the Membership role when the new post was in place. It was also suggested that the GP Relationship Manager should attend as required. After some discussion it was agreed that 2.2 section d Ensuring the Hospital and Trust material is issued in plain English, free of jargon and unexplained initials should remain on the Terms of Reference but have 'when requested' added. There was some discussion about the frequency of the meetings. It was agreed the meetings would take place every 2 months but the day to be reviewed. It was also agreed that there should be a work plan, which the secretary of the meeting and the chairman should agree. Otherwise the terms of reference were approved for presentation to the Members' Council.

5. Review of Constitutional arrangements for membership

This was discussed in some detail and the group commented that they had not anticipated this particular aspect of changing to 'opt out'. After some discussion it was agreed that option 1 would be the one that was proposed to the Members' Council.

6. Membership and Funding – period ended 31 Mar 09

It was suggested that the column headed Next Year Estimated should be headed Next Year Target. CM said that the targets had been agreed with the Chairman ie the emphasis to be on maintaining the current membership. This is due to the economic climate, the cost of recruitment and that there are more Foundation Trusts with which to compete. It was noted that on p5 4th para the term 'resident' should be replaced with 'patient panels'.

7. Membership Development and Communications Strategy

There was some confusion as this Development Strategy was dated Jul 08 but the one on the website was dated Sep 08. CM said she would seek clarification on this. She felt that a lot of the strategy had been taken out as this had been designed for when we launched the application to become a Foundation Trust and she felt that there could be further reduction of the introduction. This was agreed, and that it would be beneficial to update section 3.1 if this data was available. It was pointed out that some sections appeared to be missing from the top of p5. It was also suggested that there were some more headings in the section to make it more readable.

The meeting went through each of the objectives. Membership surgeries were discussed and were felt not to be an effective use of resources. JB said that she felt that face to face recruitment was the best option. 'To run membership surgeries and track progress' was replaced with 'To maximise PALS for recruitment (and feedback)'. It was agreed to add an objective about encouraging commentary on the future direction of the Trust services provision, public consultations of relevance including access to services and other areas. Section 5.3 Communication. It was agreed that the first paragraph should be made more formal in line with the rest of the document. The fourth objective about creating a membership area to be replaced with 'To maximise use of the Information zone and to ensure that it is responsive to members' feedback and that it contains up-to-date information'. The objective about utilising the 35-strong Members' Council to link to their constituents rather than to reach out. The objective on p8 to be slightly reworded to remove 'to'.

There was discussion about logging all comments. CM said that PALS were already in a position to log comments and we should use the existing systems. It was agreed to change that objective to say: To ensure all comments, suggestions and queries are logged, actions are taken in a timely manner and reported. However, CB did identify a gap which was ensuring that suggestions on the future of the Trust were picked up as PALS tended to respond to comments and queries. JK commented on a bad experience that she had had in A&E. She had contacted PALS but was told to put it in writing. CM said that that was probably because PALS felt the nature of her concerns warranted a complaint. She pointed out that lots of people are reluctant to put their complaints in writing and this may actually reduce the number of complaints.

CM drew attention to the objective tracker on the back, which would not be part of the strategy but which is there to update the committee on progress and ultimately to update the Members' Council on the activities of the committee. She suggested that when the strategy is presented that this is also presented as a separate paper. The committee agreed the progress although two areas were asked for further information. The first of these was reference 1.8 - what happened to the suggestion of an online application facility? CB also pointed out that he thought the original plans had a desk or a bench or somewhere to write. The second was that current status for section 2.2 needs clarification.

8. Diversity

It was agreed to defer this as AM and DH were both absent from the meeting.

9. GP Survey Results

AP circulated a copy of the GP survey. She pointed out that only 10% of the GPs had replied, however it did confirm the main concerns that she had already identified. She confirmed the survey would be repeated annually. She outlined the main feedback from the GP survey. She circulated the paediatric directory and asked the group if they would support a request to the MC to fund the publication of the full directory for the Trust. There was overwhelming support for this. CM said that the Trust had recently found out that they had won the bid.

10. Open Day Feedback

Claire circulated the Dr Foster response. There were slightly less people than last year (about 100). CB felt that the last question 'Did you find everything you were looking for?' was not very helpful as it does not say specifically what was missing if the answer was no. Overall it was felt to be a success. One comment was that there should be larger notices identifying stands and more music.

11. Seasonal Working Conference Feedback

This was deferred as AM was not present.

12. Trust News Feedback

CK asked for comments on the new style and reported on the Trust survey on communication. CB said initially he had not liked the new style but now did. CK confirmed that the next edition would be in Aug/Sep and asked for suggestions for content.

13. The Information Zone

CM suggested that one of the screens could be used to encourage people to sign up for research. This was agreed. CB said that there needed to be more content in this.

14. Any Other Business

There was none.

5. DATE OF NEXT MEETING

Tuesday 25th August 2009 4.00pm

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Quarterly Meeting
18 June 2009

AGENDA ITEM NO.	2.2d/May/09
PAPER	Membership Development & Communications Strategy 09/10
AUTHOR	Dianne Holman, Interim FT Secretary
LEAD	Martin Rowell, Chairman
EXECUTIVE SUMMARY	The paper is an update of the July 2008 version of the Membership Development & Communications Strategy. It is prepared in draft for agreement and subsequent presentation to the Annual Members' Meeting
DECISION / ACTION	The meeting is asked to discuss and agree the content.

Membership Development and Communication Strategy

June 2009

Content **Page**

1.0 Introduction

Building and maintaining a vibrant membership is a key aim for Chelsea and Westminster Hospital NHS Foundation Trust. This document defines the membership community and describes how the Trust will grow the membership, ensure diversity and encourage engagement.

2.0 Our Membership

The Trust will focus in 2009-10 on achieving sustainable growth which includes the retention of existing members as well as the recruitment of new ones.

Public
The most critical challenge is the public constituency where the default method of joining is opt-in. The Trust does not believe that it can significantly increase numbers in the public constituency without overwhelming the operational and financial capacity of the Trust. There are now more Foundation Trusts in London competing for members and it is now much more difficult and costly to recruit new members. The Trust's target is to maintain the size of the membership in the public constituency in 2009-10.

Patients
In the patient constituency, the Trust aims for growth of 5% through the continued use of its new discharge booklet which was developed in late 2008 and which contains a membership application form at the back. The feedback received is that this method has been successful and the Trust expects to see the full-year effect of this method in 2009-10.

Staff
The Trust received approval from Monitor for an 'opt out' system for staff and this has been implemented.

General
The Trust embarked on a number of initiatives in the 2008/09 to develop its branding and engage its membership and expects to see the rewards in 2009-10. Part of this will be the use of the Information Zone, which is a dedicated area equipped with electronic kiosks and an information screen, with the aim of promoting communication and engagement with members.

The Trust has recruited a dedicated Membership and Engagement Manager with responsibility for supporting the Members' Council in developing approaches to engaging and working with the membership. The Trust will also use its Seasonal Working Conferences, Patients' Panels and links with the Patient Advice and Liaison Service to network and develop the membership.

The Trust will continue to promote two week-long membership recruitment campaigns linked to the Open Day and the Annual Members' Meeting.

Approximately 60% of Council Members seats will become vacant in the autumn as some of the original Council Members come to the end of their term. The election will be an opportunity for the Trust to generate another wave of interest in membership when it

invites nominations for the various vacant seats in the autumn. The Trust will encourage nominees who are able and willing to network in their communities.

These initiatives will serve to both increase membership size as well as engage with our existing members and we will track and report on progress regularly.

3.0 Ensuring the Diversity of Our Membership

The Trust recognises the need for membership of the public constituency to be representative of the communities which it serves. The Trust has identified three (3) areas for further development:

Geographical[1]
Penetration in the Wandsworth One sub-constituency is significantly below the benchmark of 1% of the local population. This includes the catchment area of Earlsfield, Fairfield, Roehampton, Southfields, Thamesfield, Tooting, Wandsworth Common, Westhhill and West Putney.

Age[2]
The distribution of the membership in the under-40 age group is significantly lower than the general population; however, the trend reversed past the age of 40.

Socio-Economic Groups[3]
Based on profiling by postcode, the distribution of the Trust's membership is significantly higher in the lowest social group than in the general population and is significantly lower in the highest social group.

3.1 Our local population

We would like the public membership to be representative of our geographical location and reflect the age, gender, ethnicity and socio-economic groups of our local population. It will be important to continue to recruit members to the Foundation Trust in order to reflect the changing population we serve.

The communities that will be represented in the membership are staff, patients of the hospital and their carers, and those residents within the local authority boundaries of The City of Westminster, The Royal Borough of Kensington and Chelsea, the Borough of Hammersmith and Fulham and the Borough of Wandsworth. – according to the Office for National Statistics (last updated Nov 2004), this represents a population of 765,827 residents.

The area is densely populated with a predominantly young and ethnically diverse population, while there are areas of extreme affluence there are also areas of deprivation in close proximity. A brief health profile for each of our local boroughs is provided below to help us target membership.

[1] Analysis by Computershare -See Appendix 1
[2] Analysis by Computershare – See Appendix 2
[3] Analysis by Computershare – see Appendix 3

General Health Profile[4]

Overall, the health of people in Kensington and Chelsea is significantly better than the England average. Data sourced from the Office for National Statistics (last updated Nov 2004) indicate that there is a higher percentage of persons in good health in the Trust's catchment area than in London or England.

The percentage of persons in good health in these four boroughs ranged from 72.4% to 75.2%. This exceeded the average London of 70.8% and the average for England of 68.8%.

Age Profile[5]

There are a number of features in common among these boroughs. Compared to the UK average:

- There is a higher distribution in the 20-39 age group
- There is a lower distribution in the 5-19 age group
- There is a lower distribution in the 45+ age group; except for Kensington and Chelsea where the turning point is at 65+
- There is an even distribution in the under 5 age group; except for Westminster, where the figure is slightly lower.

Ethnicity Profile[6]

Data sourced from the Office for National Statistics (last updated Nov 2004) indicate that there is a higher percentage of persons of White, Mixed and Chinese ethnicity in the Trust's catchment area than in London or England and a lower percentage of persons of Black or Asian ethnicity.

The most significant variation occurs in the group *Whites*. With the exception of Wandsworth, there is a lower percentage of *Whites: British* than in London. In all boroughs there is a significantly higher percentage of *Whites: Other White*.

Socio-economic profile

The Trust's catchment area is a relatively affluent segment of London with very little variation between boroughs in the under £60k income category.[7]

% of households with income	Average	Standard Deviation
Under £15k (London average £22k)	17	1
Under £30k (London average £53k)	45	2
Under 60k (London average £85k)	79	1

Data sourced from the Office for National Statistics (last updated Nov 2004) indicate that there is a significantly higher percentage of persons in managerial and professional

[4] See Appendix 4
[5] See Appendix 5 - 8
[6] See Appendix 9
[7] See Appendix 10

occupations in the Trust's catchment area than in London or England and a significantly lower percentage of persons in other socio-economic groups.[8]

The Trust is committed to encouraging all qualifying individuals to become active members of Chelsea and Westminster.

4.0 Resources for Membership Development

The Membership Development and Communications Strategy will be overseen by the combined team efforts of the Membership and Engagement Manager and the MPALS Office under the direction of the Director of Nursing and the Head of Communications under the direction of the Director of Governance and Corporate Affairs.

A recurring budget of £100,000 per financial year is made available to the Members' Council to spend at their discretion on relevant projects.

5.0 OBJECTIVES

Chelsea and Westminster Hospital NHS Foundation Trust is a public benefit organisation; open to all our patients, their carers, people who live in our public constituencies and staff, without gender, social, racial, political, or religious discrimination.

In conjunction with the Members' Council, the Trust will deliver the objectives outlined below.

5.1 Objectives - membership recruitment

- To provide a simple, accessible and publicised process for becoming a member which meets the needs of our diverse population.
- To set and meet targets for increasing membership in each constituency as set out in the annual plan.
- To maintain accurate and informative databases of members to meet regulatory requirements and to be a tool for developing membership.
- To conduct a regular recruitment drive focussed on patients and the public.
- To agree a schedule for Council Members to recruit within the hospital on a regular basis.
- To maximise PALS as a resource for recruitment and feedback.
- To work in partnership with other organisations to increase membership e.g. PCTs

[8] See appendix 11

5.2 Objectives – membership engagement

- To record those members who are interested in getting involved with the Trust and ensure that they are encouraged and given ample opportunities to get involved e.g. Open Day, Focus Groups, AGM, Consultations and to encourage encourage them and give them ample opportunities to stand for election to the Members Council.

- To link with the Trust's existing work and strategies on user and public involvement particularly working with existing user groups and representatives.

- To inform members and obtain support and involvement where relevant on the Trust's future direction and developments and service provision. To consult on issues of relevance e.g. access to services.

5.3 Communication

The Trust will maintain contact with our members through the range of methods including members' meetings and meetings of the Members' Council, road shows, the Annual report, website and the Information Zone.

Objectives – communicating with members

- To maintain membership communications strategy and evaluate methods of communication used.

- To ensure communications are used to stimulate membership involvement as well as members to run for the Members' Council.

- To identify opportunities for and facilitate two-way communications between membership and Members' Council

- To maximise use of the Information Zone where members can learn more about the Trust, identify and meet with their Council Representative and meet other members.

- To be responsive to members' feedback and ensure that Information Zone contains up-to-date information.

- To utilise our 35-strong Members' Council as a link to their constituents and promote the Trust

- To ensure staff and the directorates use the membership mailing to communicate on service developments and other relevant information

6.0 Measurement and Evaluation of Success

The Members' Council and the Communications Sub-Committee will have a key role in implementing and monitoring the effectiveness of this strategy and ensuring that it remains a meaningful and relevant document as the membership of the trust matures.

The Members' Council and the Trust Board will:

Objectives

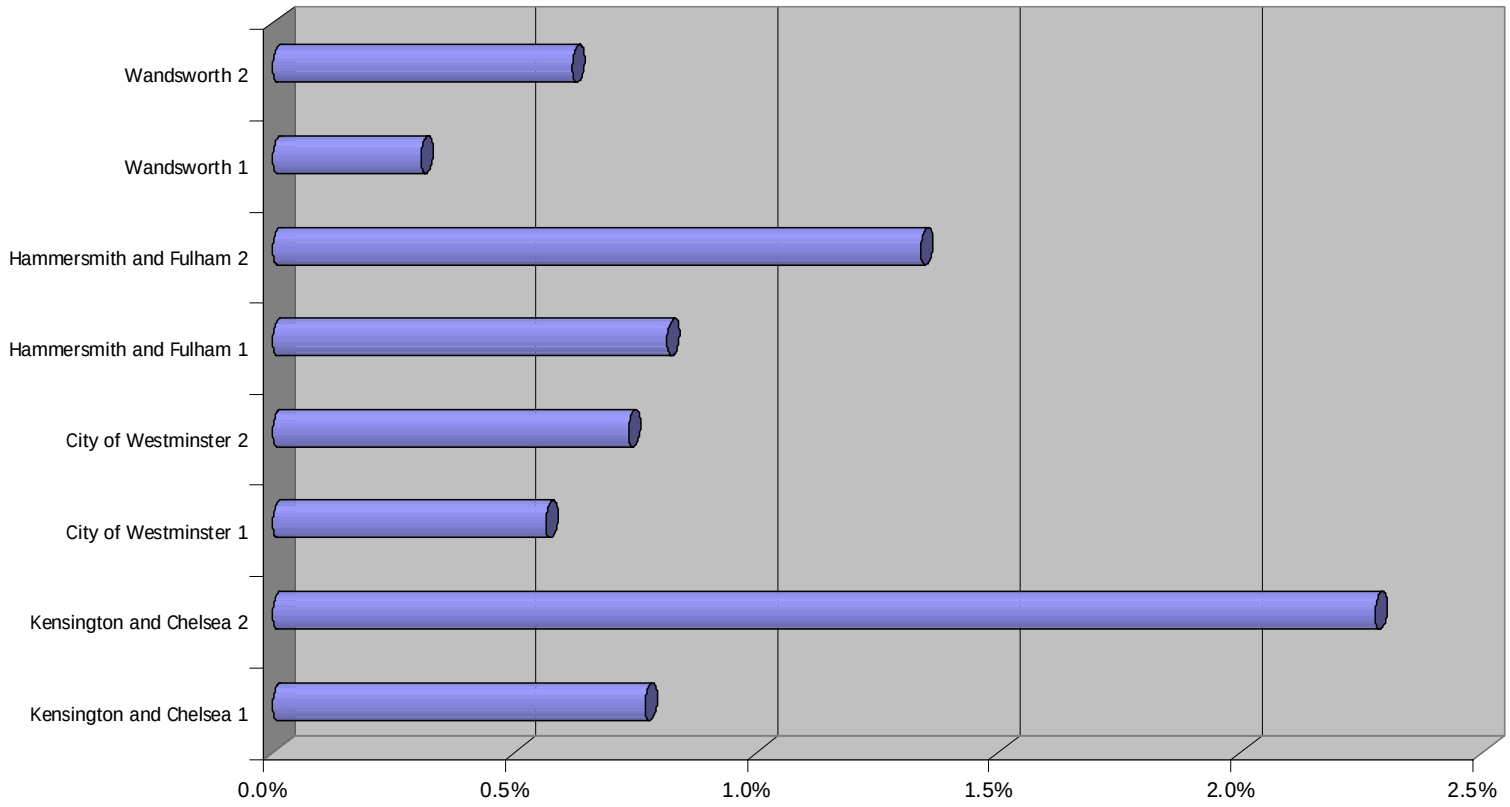
- Assess the composition of membership to ensure that it reflects the diversity of the local communities in which we operate.

- Monitor the contribution membership has made to service development and improvement.

- Ensure all comments, suggestions and queries are logged and action is taken in a timely manner and reported to the Members' Council.

- To review the objectives included in this strategy and monitor progress.

APPENDICES


Wandsworth 2
Wandsworth 1
Hammersmith and Fulham 2
Hammersmith and Fulham 1
City of Westminster 2
City of Westminster 1
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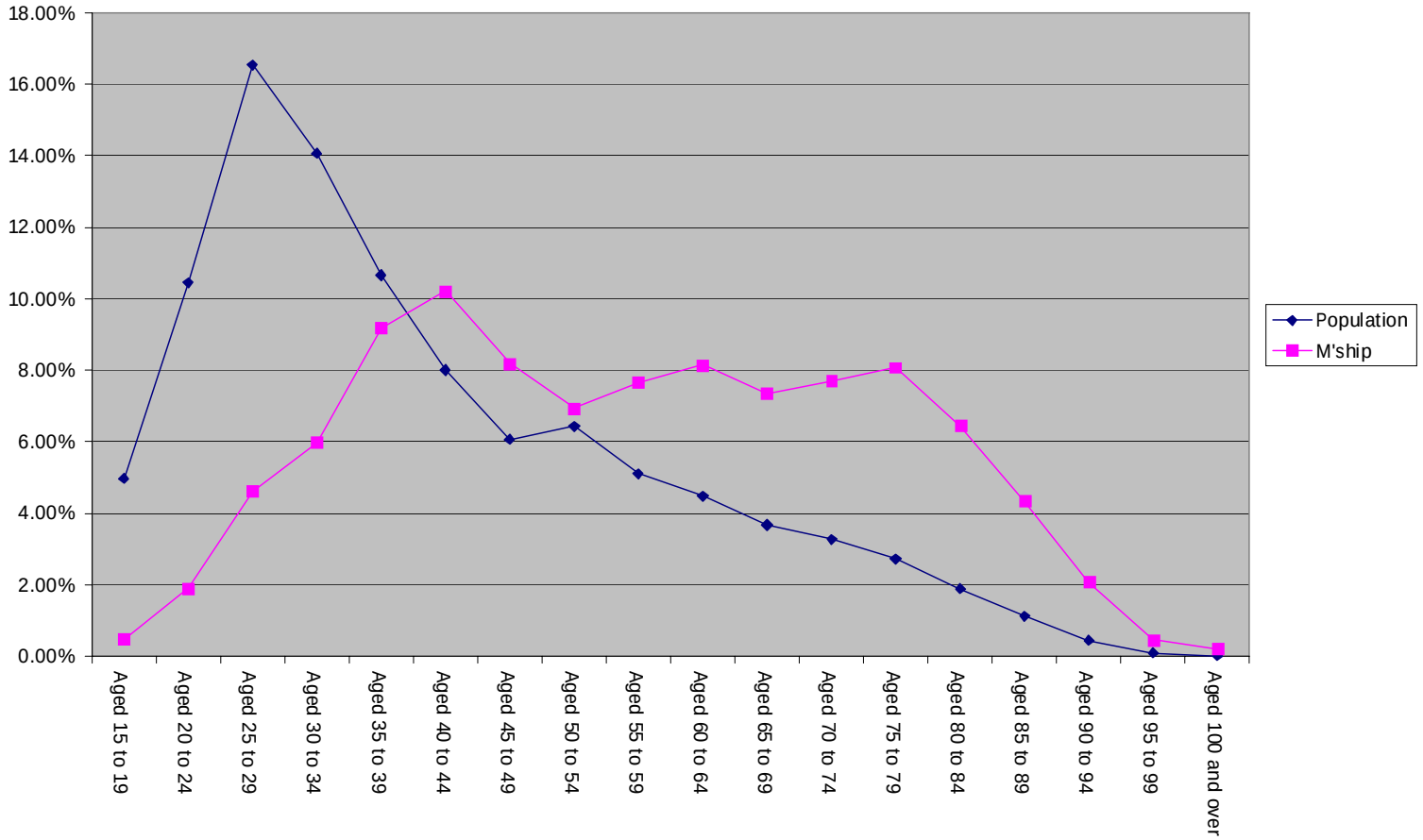
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Aged 65 to 69
Aged 70 to 74
Aged 75 to 79
Aged 80 to 84
Aged 85 to 89
Aged 90 to 94
Aged 95 to 99
Aged 100 and over
Population
M'ship

		Profile	%	Base	%	Penetration %	Z-Score	Index	0 100 200
1	Wealthy Achievers	6	0.1	2,691	0.3	0.2	-3	34	
2	Urban Prosperity	4,637	73.4	758,390	78.5	0.6	-10	93	
3	Comfortably Off	64	1.0	14,144	1.5	0.5	-3	69	
4	Moderate Means	20	0.3	2,387	0.2	0.8	1	128	
5	Hard Pressed	1,589	25.2	187,964	19.5	0.8	11	129	
	Unclassified	232		7,008					
	Total (excl. Unclassifieds)	**6,316**		**965,576**		**0.7**			

Appendix 4 General Health Profile

Data sourced from the Office for National Statistics (last updated Nov 2004)

GENERAL HEALTH	Kensington and Chelsea	Hammersmith and Fulham	Westminster	Wandsworth	London	England
All People (Persons)1	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Good Health (Persons)1	75.2%	73.0%	72.4%	74.6%	70.8%	68.8%
Fairly Good Health (Persons)1	17.3%	18.8%	19.0%	18.3%	20.9%	22.2%
Not Good Health (Persons)1	7.5%	8.2%	8.6%	7.2%	8.3%	9.0%

Appendices 5 - 8
The figures are taken from
http://www.statistics.gov.uk/census2001/pyramids/pages/00bj.asp

Kensington and Chelsea

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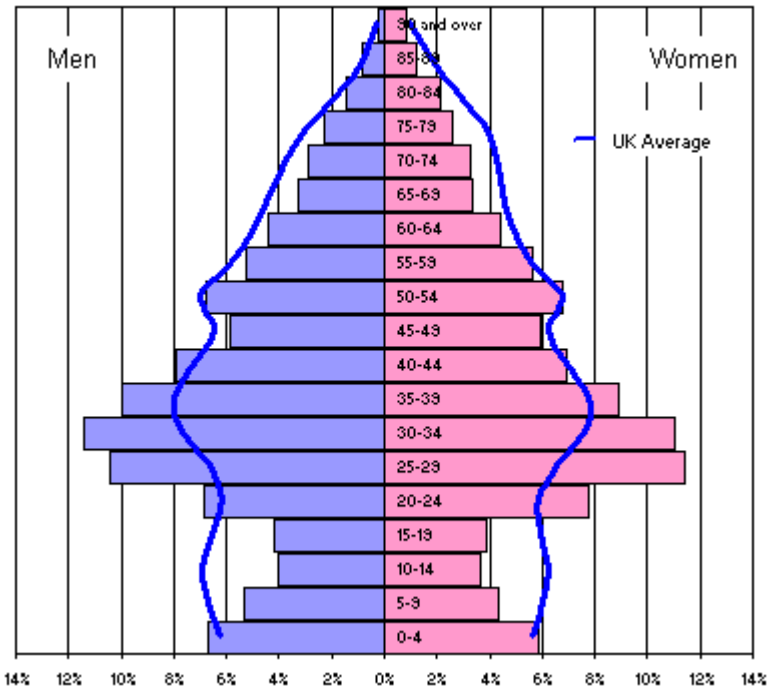

The percentages on the pyramid represent the percentage of 'all males' (to the left) and the percentage of 'all females' (to the right) that are in that age group.

Age Range	Total	Males	Females
0 - 4	9953	5104	4849
5 - 9	7643	4074	3569
10 - 14	6093	3036	3057
15 - 19	6397	3168	3229
20 - 24	11662	5222	6440
25 - 29	17388	7890	9498
30 - 34	17817	8648	9169
35 - 39	14952	7565	7387
40 - 44	11737	5989	5748
45 - 49	9378	4451	4927
50 - 54	10798	5172	5626
55 - 59	8660	3990	4670
60 - 64	7026	3339	3687
65 - 69	5235	2470	2765
70 - 74	4924	2184	2740
75 - 79	3857	1742	2115
80 - 84	2893	1121	1772
85 - 89	1649	611	1038
90 and over	857	183	674
Totals	158919	75959	82960

Hammersmith and Fulham

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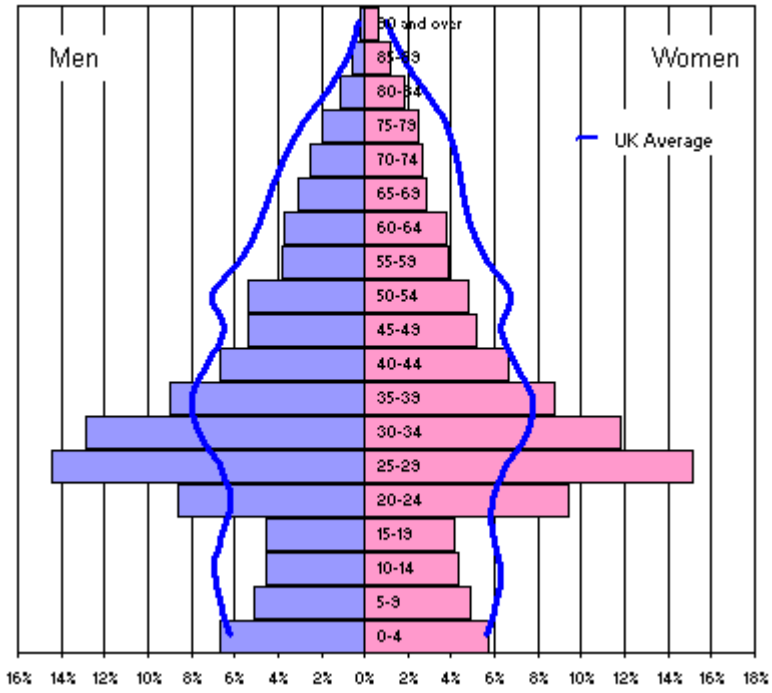

The percentages on the pyramid represent the percentage of 'all males' (to the left) and the percentage of 'all females' (to the right) that are in that age group.

Age Range	Total	Males	Females
0 - 4	10195	5282	4913
5 - 9	8292	4056	4236
10 - 14	7377	3610	3767
15 - 19	7189	3579	3610
20 - 24	14938	6827	8111
25 - 29	24453	11427	13026
30 - 34	20347	10193	10154
35 - 39	14609	7090	7519
40 - 44	11022	5283	5739
45 - 49	8657	4221	4436
50 - 54	8378	4238	4140
55 - 59	6320	2976	3344
60 - 64	6123	2903	3220
65 - 69	4854	2392	2462
70 - 74	4264	1953	2311
75 - 79	3678	1537	2141
80 - 84	2441	862	1579
85 - 89	1436	420	1016
90 and over	669	144	525
Totals	165242	78993	86249

Westminster

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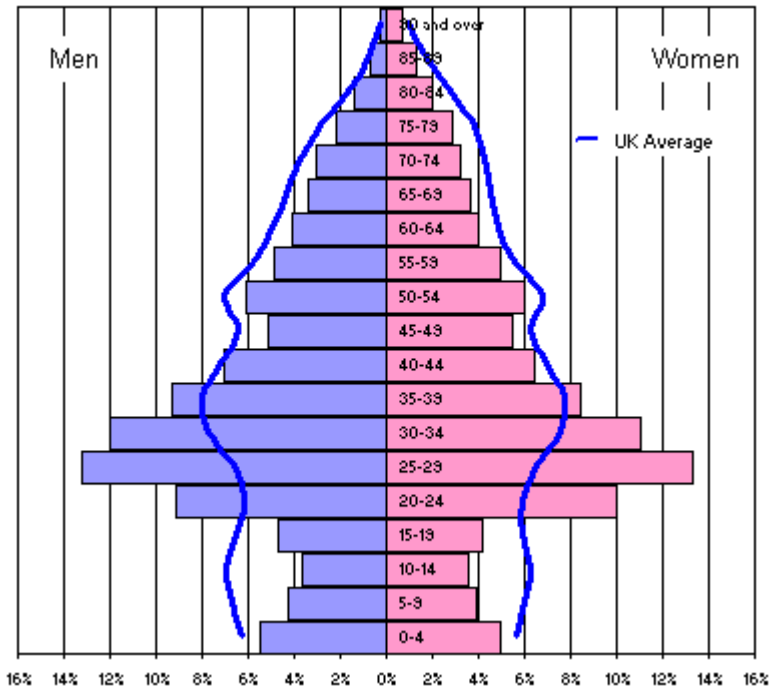

The percentages on the pyramid represent the percentage of 'all males' (to the left) and the percentage of 'all females' (to the right) that are in that age group.

Age Range	Total	Males	Females
0 - 4	9452	4842	4610
5 - 9	7436	3783	3653
10 - 14	6477	3218	3259
15 - 19	8049	4194	3855
20 - 24	17369	8140	9229
25 - 29	24028	11730	12298
30 - 34	20912	10693	10219
35 - 39	16103	8270	7833
40 - 44	12200	6239	5961
45 - 49	9614	4572	5042
50 - 54	10956	5410	5546
55 - 59	8946	4356	4590
60 - 64	7333	3625	3708
65 - 69	6388	3038	3350
70 - 74	5688	2693	2995
75 - 79	4542	1928	2614
80 - 84	3060	1238	1822
85 - 89	1851	612	1239
90 and over	882	226	656
Totals	181286	88807	92479

Wandsworth

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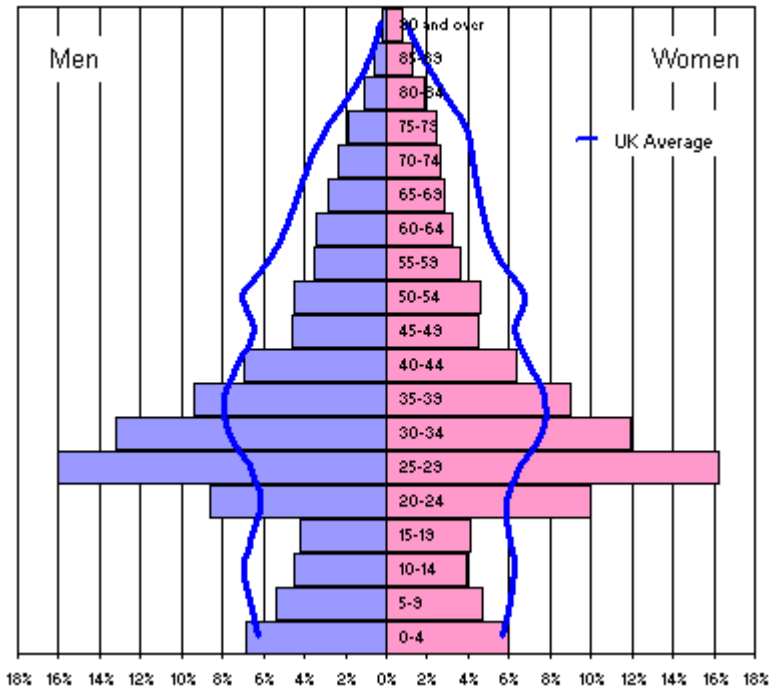


The percentages on the pyramid represent the percentage of 'all males' (to the left) and the percentage of 'all females' (to the right) that are in that age group.

Age Range	Total	Males	Females
0 - 4	16660	8503	8157
5 - 9	13069	6616	6453
10 - 14	10952	5590	5362
15 - 19	10742	5179	5563
20 - 24	24223	10630	13593
25 - 29	42020	19851	22169
30 - 34	32669	16332	16337
35 - 39	23862	11561	12301
40 - 44	17250	8593	8657
45 - 49	11837	5667	6170
50 - 54	11877	5624	6253
55 - 59	9310	4348	4962
60 - 64	8752	4277	4475
65 - 69	7474	3531	3943
70 - 74	6424	2848	3576
75 - 79	5658	2289	3369
80 - 84	3954	1381	2573
85 - 89	2386	671	1715
90 and over	1261	251	1010
Totals	260380	123742	136638

Appendix 9

Data sourced from the Office for National Statistics (last updated Nov 2004)

ETHNICITY	Kensington and Chelsea	Hammersmith and Fulham	Westminster	Wandsworth	London	England
All People (Persons)1	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
White (Persons)1	78.6%	77.8%	73.2%	78.0%	71.2%	90.9%
White: British (Persons)1	50.1%	58.0%	48.5%	64.8%	59.8%	87.0%
White: Irish (Persons)1	3.3%	4.8%	3.6%	3.1%	3.1%	1.3%
White: Other White (Persons)1	25.3%	15.0%	21.1%	10.0%	8.3%	2.7%
Mixed (Persons)1	4.1%	3.8%	4.1%	3.4%	3.2%	1.3%
Mixed: White and Black Caribbean (Persons)1	0.8%	1.2%	0.8%	1.1%	1.0%	0.5%
Mixed: White and Black African (Persons)1	0.7%	0.6%	0.7%	0.5%	0.5%	0.2%
Mixed: White and Asian (Persons)1	1.2%	1.0%	1.3%	0.9%	0.8%	0.4%
Mixed: Other Mixed (Persons)1	1.4%	1.0%	1.4%	0.9%	0.9%	0.3%
Asian or Asian British (Persons)1	4.9%	4.4%	8.9%	6.9%	12.1%	4.6%
Asian or Asian British: Indian (Persons)1	2.0%	1.7%	3.1%	2.8%	6.1%	2.1%
Asian or Asian British: Pakistani (Persons)1	0.8%	1.0%	1.0%	2.1%	2.0%	1.4%
Asian or Asian British: Bangladeshi (Persons)1	0.7%	0.6%	2.8%	0.4%	2.1%	0.6%
Asian or Asian British: Other Asian (Persons)1	1.4%	1.1%	2.0%	1.6%	1.9%	0.5%
Black or Black British (Persons)1	7.0%	11.1%	7.4%	9.6%	10.9%	2.3%
Black or Black British: Caribbean (Persons)1	2.6%	5.2%	3.1%	4.9%	4.8%	1.1%
Black or Black British: African (Persons)1	3.8%	4.9%	3.7%	3.8%	5.3%	1.0%
Black or Black British: Other Black (Persons)1	0.6%	1.1%	0.7%	0.9%	0.8%	0.2%
Chinese or Other Ethnic Group (Persons)1	5.5%	2.8%	6.3%	2.1%	2.7%	0.9%
Chinese or Other Ethnic Group: Chinese (Persons)1	1.6%	0.8%	2.2%	0.9%	1.1%	0.4%
Chinese or Other Ethnic Group: Other Ethnic Group (Persons)1	3.8%	2.0%	4.1%	1.3%	1.6%	0.4%

Appendix 10
The figures are taken from
http://www.londoncouncils.gov.uk/londonfacts/londonstatistics/Householdincomedistributionin200607.htm

London borough	% households with income under 15k	% households with income under 30k	% households with income under 60k
City of London	12	36	72
Barking and Dagenham	30	66	92
Barnet	22	53	85
Bexley	24	57	88
Brent	26	60	89
Bromley	19	50	83
Camden	18	48	81
Croydon	23	55	86
Ealing	23	55	86
Enfield	25	58	88
Greenwich	24	57	87
Hackney	24	57	87
Hammersmith and Fulham	18	47	80
Haringey	23	55	85
Harrow	22	54	86
Havering	24	58	88
Hillingdon	23	56	87
Hounslow	23	56	86
Islington	20	51	83
Kensington and Chelsea	15	42	77
Kingston upon Thames	18	48	81
Lambeth	20	51	83
Lewisham	23	56	86
Merton	20	51	83
Newham	30	65	91
Redbridge	23	56	87
Richmond upon Thames	14	41	76
Southwark	22	54	85
Sutton	21	53	85
Tower Hamlets	23	54	84
Waltham Forest	25	58	88
Wandsworth	17	45	79
Westminster	16	44	78
London average	22	53	85

Appendix 11

Data sourced from the Office for National Statistics (last updated Nov 2004)

SOCIO_ECONOMIC	Kensington and Chelsea	Hammersmith and Fulham	Westminster	Wandsworth	London	England
All People (Persons)1	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
1. Higher managerial and professional occupations (Persons)1	20.3%	17.9%	18.6%	19.5%	12.1%	8.6%
2. Lower managerial and professional occupations (Persons)1	25.8%	26.2%	24.2%	28.0%	22.2%	18.7%
3. Intermediate occupations (Persons)1	5.9%	8.2%	7.2%	9.0%	10.2%	9.5%
4. Small employers and own account workers (Persons)1	7.0%	6.1%	6.0%	5.5%	6.4%	7.0%
5. Lower supervisory and technical occupations (Persons)1	2.8%	3.6%	3.3%	3.6%	5.0%	7.1%
6. Semi-routine occupations (Persons)1	5.7%	6.7%	6.5%	6.7%	9.0%	11.7%
7. Routine occupations (Persons)1	3.7%	4.6%	4.0%	4.2%	5.8%	9.0%
8. Never worked and long-term unemployed (Persons)1	5.7%	5.5%	6.4%	4.2%	6.0%	3.7%
Not Classified (Persons)1	23.1%	21.0%	23.7%	19.3%	23.2%	24.7%

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Quarterly Meeting
18 June 2009

AGENDA ITEM NO.	2.2c/May/09
PAPER	Membership Tracker
AUTHOR	Dianne Holman, Interim FT Secretary
LEAD	Martin Rowell, Chairman
EXECUTIVE SUMMARY	The paper gives an update on the progress in meeting 2008-09 objectives of the Membership Development and Communications Strategy.
DECISION / ACTION	The meeting is asked to discuss and agree the content.

Membership Tracker

May 2009

Ref	OBJECTIVE	Current Status	Further Action suggested for agreement at Communications Sub-Committee in May 09
1.0	**Membership recruitment**		
1.1	To ensure there is a simple, accessible and publicised process for becoming a member which meets the needs of our diverse population.	Freepost leaflet / 0870 707 1567 (national rate) / www.chelwest.nhs.uk	
1.2	To set and meet targets for increasing membership in each constituency as set out in the Trust Annual Plan 08/09.	Fell short of targets in 2008-09 by 208 public members and 263 patient members. Extrapolating current costs, it would have costed another £80k to meet this target.	Less ambitious numbers proposed for 2009-10 having regard to financial constraints and diminishing returns.
1.3	To maintain an accurate and informative database of members which meets regulatory requirements and can be used as a tool to develop membership.	PUBLIC & PATIENTS -Outsourced and reports meets regulatory requirements. STAFF - inhouse (Workforce Information Team) reports are produced manually by cutting and pasting Excel Spreadsheets.	Development of Staff Database inhouse in MS Access with standardised fields including 'opt-out', dropdown tables, a key field record counting and automated reports; alternatively outsourcing at £1.50 per member per annum (estimate £4,395).
1.4	To run a ‘Membership Week’ to drive up patient and public membership at least twice per year.	May's Campaign is in Progress - 3 campaigners will visit NHS Surgeries, Dentists and Pharmacies in K&C over 4 weekdays to promote the Open Day and Membership.	In the week to 10th May, membership net reduction of 15 members (4 patient / 11 public). Batch of April resignations posted (-22). Therefore new recruitment is 7. Forms received but not posted is 8. Total new recruitment in week is 15 members. Compares to average weekly increase in preceding 5 weeks of -0.2.

Ref	OBJECTIVE	Current Status	Further Action suggested for agreement at Communications Sub-Committee in May 09
1.5	To provide the necessary support for Council Members to recruit within the hospital on a regular basis e.g. leaflets, name badges, clinic schedules	Leaflets and electronic kiosks are available. Information Zone is being refurbished to give greater integrity to the space.	Develop a plan for use of the area and ways to encourage visitors to come in.
1.6	To work in partnership with other organisations to increase membership e.g. PCTs	Join our Patients' Panel - give us your views on your hospital	
1.7	To design service specific membership recruitment leaflets	Withdrawn due to cost considerations.	
1.8	To ensure that any area where touch screen technology is used, we include information about membership and possibly provide an online application facility.	Touch screen technology is limited to Information Zone.	A desk, bench and somewhere to write.
2.0	**Ensuring Diversity of Membership**		
2.1	To identify the diversity of membership	Database administrator has identified areas of under-representation: age / geography / social class	To plan targeted recruitment.
2.2	To identify specific recruitment strategies to address any under representation	Discussed targeted strategies with provider. Economical if the target growth was 25% but due to very high base cost, not appropriate for more modest requirements.	
3.0	**Ensuring Engagement**		

Ref	OBJECTIVE	Current Status	Further Action suggested for agreement at Communications Sub-Committee in May 09
3.1	To record those members who are interested in getting involved with the Trust and ensure that they are given ample opportunities to get involved e.g. Open Day, Focus Groups, AGM, public consultations.	This is already a feature of the database.	Extract and use the information.
3.2	To encourage more members to stand for election to the Members' Council.	Elections are due in September 2009 and almost 60% of the Members' Council seats will become vacant. Will need to publicise well in advance.	
3.3	To link with the Trust's existing work and strategies on user and public involvement particularly working with existing user groups and representatives.	An Engagement & Membership Manager is being recruited. Interviews scheduled for May 09.	
3.4	To develop and maintain a system to record all member feedback, track progress on issues where relevant and publicise.	The governance arrangements cater for Members' Feedback through representation by the Members' Council.; however, a more structured system needs to be developed.	New Membership & Engagement Post
3.5	Introduce a programme of mystery shopping whereby Council Members would be trained to be shoppers.	For initiation by departments requiring the service.	Identify a pilot.
4.0	**Communicating with Members**		

Ref	OBJECTIVE	Current Status	Further Action suggested for agreement at Communications Sub-Committee in May 09
4.1	To maintain the membership communication strategy and evaluate methods of communication used	Needs to be updated for the Members' Council to present at the Annual Members' Meeting in Sep 2009 as required by the Constitution.	Forward recommendations for updating to Members' Council in June.
4.2	To ensure communications are used to stimulate membership involvement as well as members to run for the Members' Council	To be decided if topical seminars will again be held throughout week of AMM	
4.3	To identify opportunities for and facilitate two-way communications between the membership and Members' Council	The trust facilitates through events such as the Open Day, AMM, public meetings of the Members' Council, And more recently the Seasonal Working Conference. Also there are newsletters, mailings and the website.	Working on a model for constituent meetings to promote two-way engagement between Council Members and their constituents. Also, direct contact between the membership will be facilitated by the Council Members issuing contact details.
4.4	To create a membership area where members can learn more about the Trust, identify and meet with their Council representative and meet other members.	Information Zone is being re-furbished	Plan use for area.
4.5	To utilise our 35-strong Members' Council to promote the Trust	The Members' Council was praised by the Board for Directors for its role in responding to the recent Stroke Consultation.	

Ref	OBJECTIVE	Current Status	Further Action suggested for agreement at Communications Sub-Committee in May 09
4.6	To ensure staff and the directorates use the membership mailing to communicate on service developments and other relevant information	This is being done.	The content needs to be studied as some members resign after receiving mailings.
4.7	To work with the local media and borough-specific community groups to advertise Trust events and encourage involvement	We have had very favourable responses from NHS affiliates for requests to promote Open Day and membership.	
5.0	**Measurement and Evaluation of Success**		
5.1	To regularly assess the composition of the membership to ensure that it reflects the diversity of the local communities	Database administrator has identified areas of under-representation: age / geography / social class	Should be re-assessed annually or quarterly?
5.2	To monitor the contribution membership has made to service development and improvements	To be agreed	
5.3	To log all comments, suggestions and queries and ensure action is taken in a timely manor	Comment cards are available in the hospital. Maybe, can add a message board on the website.	New Membership & Engagement Manager to monitor responses and ensure action is taken in a timely manner.
5.4	To review the objectives included in this strategy and monitor progress	To follow from updated Membership Development Strategy approved by Members' Council.	
5.5	To monitor numbers monthly and report back to the Members' Council and the Board.	This is done.	

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Quarterly Meeting
18 June 2009

AGENDA ITEM NO.	2.2d/May/09
PAPER	Membership Development & Communications Strategy 09/10
AUTHOR	Dianne Holman, Interim FT Secretary
LEAD	Martin Rowell, Chairman
EXECUTIVE SUMMARY	The paper is an update of the July 2008 version of the Membership Development & Communications Strategy. It is prepared in draft for agreement and subsequent presentation to the Annual Members' Meeting
DECISION / ACTION	The meeting is asked to discuss and agree the content.

Membership Development and Communication Strategy

June 2009

Content **Page**

1.0 Introduction

Building and maintaining a vibrant membership is a key aim for Chelsea and Westminster Hospital NHS Foundation Trust. This document defines the membership community and describes how the Trust will grow the membership, ensure diversity and encourage engagement.

2.0 Our Membership

The Trust will focus in 2009-10 on achieving sustainable growth which includes the retention of existing members as well as the recruitment of new ones.

Public
The most critical challenge is the public constituency where the default method of joining is opt-in. The Trust does not believe that it can significantly increase numbers in the public constituency without overwhelming the operational and financial capacity of the Trust. There are now more Foundation Trusts in London competing for members and it is now much more difficult and costly to recruit new members. The Trust's target is to maintain the size of the membership in the public constituency in 2009-10.

Patients
In the patient constituency, the Trust aims for growth of 5% through the continued use of its new discharge booklet which was developed in late 2008 and which contains a membership application form at the back. The feedback received is that this method has been successful and the Trust expects to see the full-year effect of this method in 2009-10.

Staff
The Trust received approval from Monitor for an 'opt out' system for staff and this has been implemented.

General
The Trust embarked on a number of initiatives in the 2008/09 to develop its branding and engage its membership and expects to see the rewards in 2009-10. Part of this will be the use of the Information Zone, which is a dedicated area equipped with electronic kiosks and an information screen, with the aim of promoting communication and engagement with members.

The Trust has recruited a dedicated Membership and Engagement Manager with responsibility for supporting the Members' Council in developing approaches to engaging and working with the membership. The Trust will also use its Seasonal Working Conferences, Patients' Panels and links with the Patient Advice and Liaison Service to network and develop the membership.

The Trust will continue to promote two week-long membership recruitment campaigns linked to the Open Day and the Annual Members' Meeting.

Approximately 60% of Council Members seats will become vacant in the autumn as some of the original Council Members come to the end of their term. The election will be an opportunity for the Trust to generate another wave of interest in membership when it

invites nominations for the various vacant seats in the autumn. The Trust will encourage nominees who are able and willing to network in their communities.

These initiatives will serve to both increase membership size as well as engage with our existing members and we will track and report on progress regularly.

3.0 Ensuring the Diversity of Our Membership

The Trust recognises the need for membership of the public constituency to be representative of the communities which it serves. The Trust has identified three (3) areas for further development:

Geographical[1]
Penetration in the Wandsworth One sub-constituency is significantly below the benchmark of 1% of the local population. This includes the catchment area of Earlsfield, Fairfield, Roehampton, Southfields, Thamesfield, Tooting, Wandsworth Common, Westhhill and West Putney.

Age[2]
The distribution of the membership in the under-40 age group is significantly lower than the general population; however, the trend reversed past the age of 40.

Socio-Economic Groups[3]
Based on profiling by postcode, the distribution of the Trust's membership is significantly higher in the lowest social group than in the general population and is significantly lower in the highest social group.

3.1 Our local population

We would like the public membership to be representative of our geographical location and reflect the age, gender, ethnicity and socio-economic groups of our local population. It will be important to continue to recruit members to the Foundation Trust in order to reflect the changing population we serve.

The communities that will be represented in the membership are staff, patients of the hospital and their carers, and those residents within the local authority boundaries of The City of Westminster, The Royal Borough of Kensington and Chelsea, the Borough of Hammersmith and Fulham and the Borough of Wandsworth. – according to the Office for National Statistics (last updated Nov 2004), this represents a population of 765,827 residents.

The area is densely populated with a predominantly young and ethnically diverse population, while there are areas of extreme affluence there are also areas of deprivation in close proximity. A brief health profile for each of our local boroughs is provided below to help us target membership.

[1] Analysis by Computershare -See Appendix 1
[2] Analysis by Computershare – See Appendix 2
[3] Analysis by Computershare – see Appendix 3

General Health Profile[4]

Overall, the health of people in Kensington and Chelsea is significantly better than the England average. Data sourced from the Office for National Statistics (last updated Nov 2004) indicate that there is a higher percentage of persons in good health in the Trust's catchment area than in London or England.

The percentage of persons in good health in these four boroughs ranged from 72.4% to 75.2%. This exceeded the average London of 70.8% and the average for England of 68.8%.

Age Profile[5]

There are a number of features in common among these boroughs. Compared to the UK average:

- There is a higher distribution in the 20-39 age group
- There is a lower distribution in the 5-19 age group
- There is a lower distribution in the 45+ age group; except for Kensington and Chelsea where the turning point is at 65+
- There is an even distribution in the under 5 age group; except for Westminster, where the figure is slightly lower.

Ethnicity Profile[6]

Data sourced from the Office for National Statistics (last updated Nov 2004) indicate that there is a higher percentage of persons of White, Mixed and Chinese ethnicity in the Trust's catchment area than in London or England and a lower percentage of persons of Black or Asian ethnicity.

The most significant variation occurs in the group *Whites*. With the exception of Wandsworth, there is a lower percentage of *Whites: British* than in London. In all boroughs there is a significantly higher percentage of *Whites: Other White*.

Socio-economic profile

The Trust's catchment area is a relatively affluent segment of London with very little variation between boroughs in the under £60k income category.[7]

% of households with income	Average	Standard Deviation
Under £15k (London average £22k)	17	1
Under £30k (London average £53k)	45	2
Under 60k (London average £85k)	79	1

Data sourced from the Office for National Statistics (last updated Nov 2004) indicate that there is a significantly higher percentage of persons in managerial and professional

[4] See Appendix 4
[5] See Appendix 5 - 8
[6] See Appendix 9
[7] See Appendix 10

occupations in the Trust's catchment area than in London or England and a significantly lower percentage of persons in other socio-economic groups.[8]

The Trust is committed to encouraging all qualifying individuals to become active members of Chelsea and Westminster.

4.0 Resources for Membership Development

The Membership Development and Communications Strategy will be overseen by the combined team efforts of the Membership and Engagement Manager and the MPALS Office under the direction of the Director of Nursing and the Head of Communications under the direction of the Director of Governance and Corporate Affairs.

A recurring budget of £100,000 per financial year is made available to the Members' Council to spend at their discretion on relevant projects.

5.0 OBJECTIVES

Chelsea and Westminster Hospital NHS Foundation Trust is a public benefit organisation; open to all our patients, their carers, people who live in our public constituencies and staff, without gender, social, racial, political, or religious discrimination.

In conjunction with the Members' Council, the Trust will deliver the objectives outlined below.

5.1 Objectives - membership recruitment

- To provide a simple, accessible and publicised process for becoming a member which meets the needs of our diverse population.
- To set and meet targets for increasing membership in each constituency as set out in the annual plan.
- To maintain accurate and informative databases of members to meet regulatory requirements and to be a tool for developing membership.
- To conduct a regular recruitment drive focussed on patients and the public.
- To agree a schedule for Council Members to recruit within the hospital on a regular basis.
- To maximise PALS as a resource for recruitment and feedback.
- To work in partnership with other organisations to increase membership e.g. PCTs

[8] See appendix 11

5.2 Objectives – membership engagement

- To record those members who are interested in getting involved with the Trust and ensure that they are encouraged and given ample opportunities to get involved e.g. Open Day, Focus Groups, AGM, Consultations and to encourage encourage them and give them ample opportunities to stand for election to the Members Council.

- To link with the Trust's existing work and strategies on user and public involvement particularly working with existing user groups and representatives.

- To inform members and obtain support and involvement where relevant on the Trust's future direction and developments and service provision. To consult on issues of relevance e.g. access to services.

5.3 Communication

The Trust will maintain contact with our members through the range of methods including members' meetings and meetings of the Members' Council, road shows, the Annual report, website and the Information Zone.

Objectives – communicating with members

- To maintain membership communications strategy and evaluate methods of communication used.

- To ensure communications are used to stimulate membership involvement as well as members to run for the Members' Council.

- To identify opportunities for and facilitate two-way communications between membership and Members' Council

- To maximise use of the Information Zone where members can learn more about the Trust, identify and meet with their Council Representative and meet other members.

- To be responsive to members' feedback and ensure that Information Zone contains up-to-date information.

- To utilise our 35-strong Members' Council as a link to their constituents and promote the Trust

- To ensure staff and the directorates use the membership mailing to communicate on service developments and other relevant information

6.0 Measurement and Evaluation of Success

The Members' Council and the Communications Sub-Committee will have a key role in implementing and monitoring the effectiveness of this strategy and ensuring that it remains a meaningful and relevant document as the membership of the trust matures.

The Members' Council and the Trust Board will:

Objectives

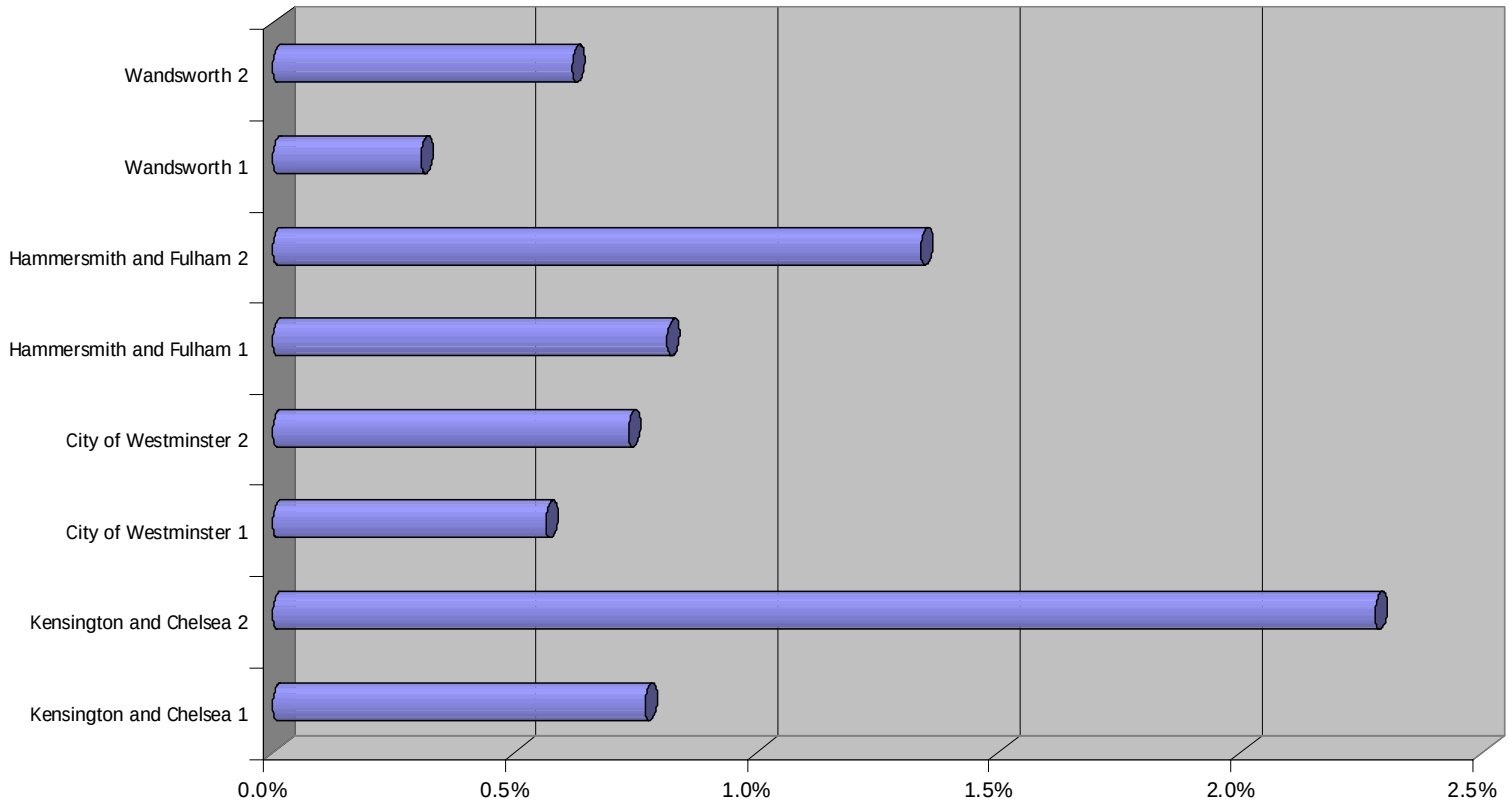
- Assess the composition of membership to ensure that it reflects the diversity of the local communities in which we operate.

- Monitor the contribution membership has made to service development and improvement.

- Ensure all comments, suggestions and queries are logged and action is taken in a timely manner and reported to the Members' Council.

- To review the objectives included in this strategy and monitor progress.

APPENDICES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Wandsworth 1
Hammersmith and Fulham 2
Hammersmith and Fulham 1
City of Westminster 2
City of Westminster 1
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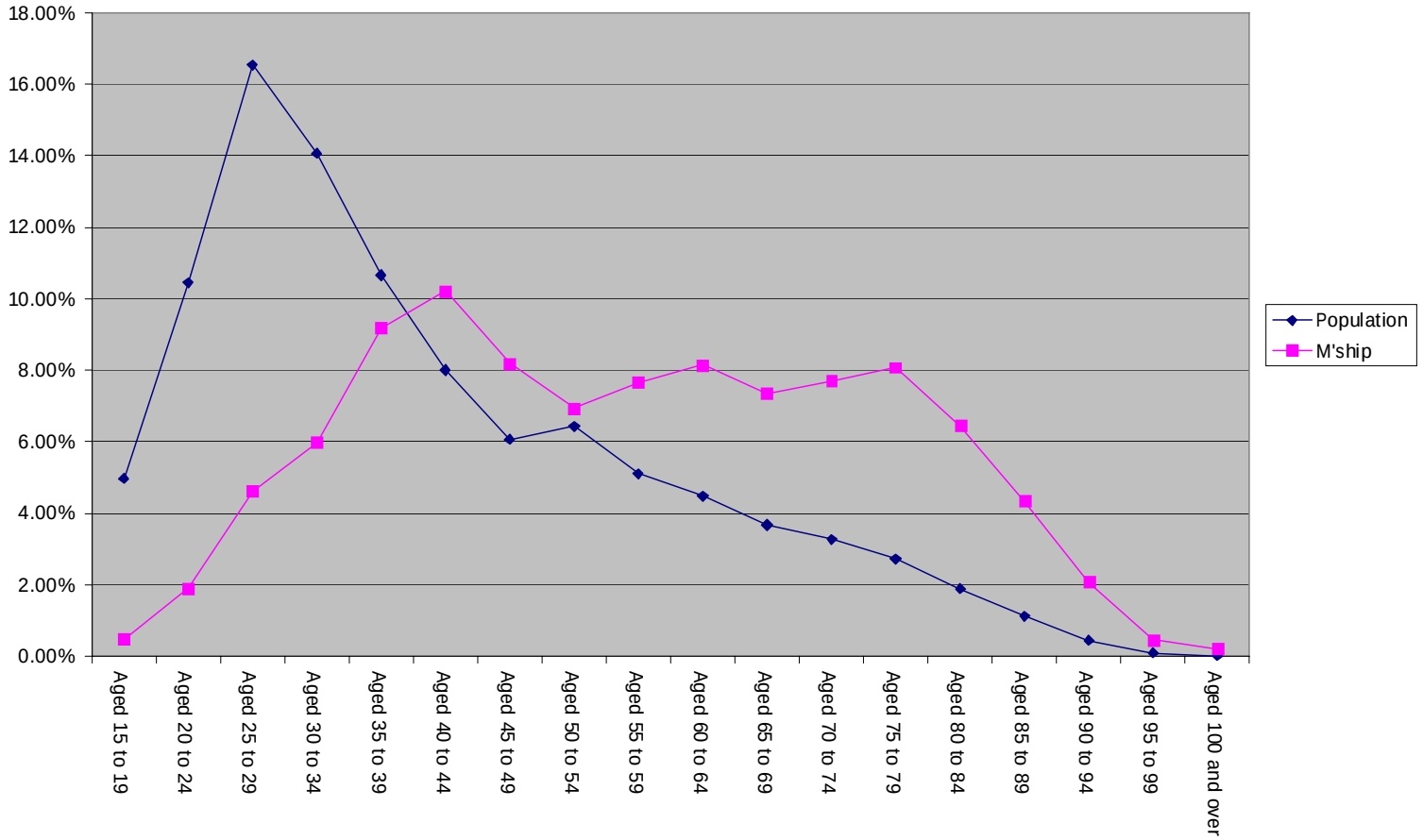
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Aged 75 to 79
Aged 80 to 84
Aged 85 to 89
Aged 90 to 94
Aged 95 to 99
Aged 100 and over
Population
M'ship

		Profile	%	Base	%	Penetration %	Z-Score	Index	0 100 200
1	Wealthy Achievers	6	0.1	2,691	0.3	0.2	-3	34	
2	Urban Prosperity	4,637	73.4	758,390	78.5	0.6	-10	93	
3	Comfortably Off	64	1.0	14,144	1.5	0.5	-3	69	
4	Moderate Means	20	0.3	2,387	0.2	0.8	1	128	
5	Hard Pressed	1,589	25.2	187,964	19.5	0.8	11	129	
	Unclassified	232		7,008					
	Total (excl. Unclassifieds)	**6,316**		**965,576**		**0.7**			

Appendix 4 General Health Profile

Data sourced from the Office for National Statistics (last updated Nov 2004)

GENERAL HEALTH	Kensington and Chelsea	Hammersmith and Fulham	Westminster	Wandsworth	London	England
All People (Persons)1	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Good Health (Persons)1	75.2%	73.0%	72.4%	74.6%	70.8%	68.8%
Fairly Good Health (Persons)1	17.3%	18.8%	19.0%	18.3%	20.9%	22.2%
Not Good Health (Persons)1	7.5%	8.2%	8.6%	7.2%	8.3%	9.0%

Appendices 5 - 8
The figures are taken from
http://www.statistics.gov.uk/census2001/pyramids/pages/00bj.asp

Kensington and Chelsea

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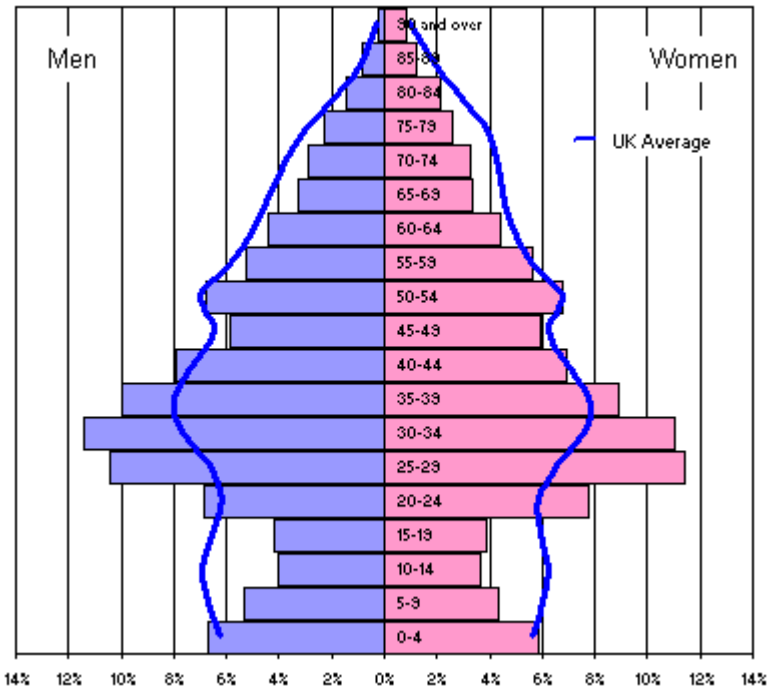

The percentages on the pyramid represent the percentage of 'all males' (to the left) and the percentage of 'all females' (to the right) that are in that age group.

Age Range	Total	Males	Females
0 - 4	9953	5104	4849
5 - 9	7643	4074	3569
10 - 14	6093	3036	3057
15 - 19	6397	3168	3229
20 - 24	11662	5222	6440
25 - 29	17388	7890	9498
30 - 34	17817	8648	9169
35 - 39	14952	7565	7387
40 - 44	11737	5989	5748
45 - 49	9378	4451	4927
50 - 54	10798	5172	5626
55 - 59	8660	3990	4670
60 - 64	7026	3339	3687
65 - 69	5235	2470	2765
70 - 74	4924	2184	2740
75 - 79	3857	1742	2115
80 - 84	2893	1121	1772
85 - 89	1649	611	1038
90 and over	857	183	674
Totals	158919	75959	82960

Hammersmith and Fulham

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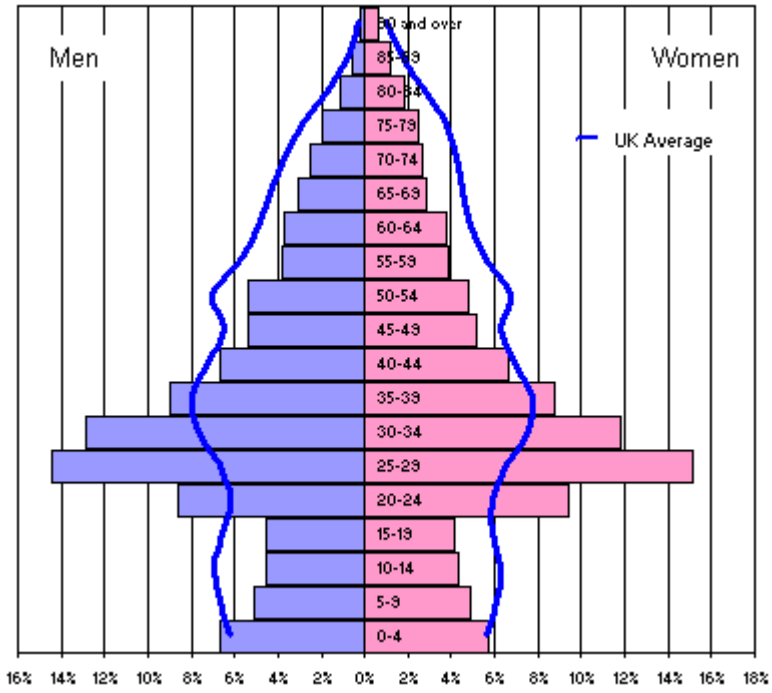

The percentages on the pyramid represent the percentage of 'all males' (to the left) and the percentage of 'all females' (to the right) that are in that age group.

Age Range	Total	Males	Females
0 - 4	10195	5282	4913
5 - 9	8292	4056	4236
10 - 14	7377	3610	3767
15 - 19	7189	3579	3610
20 - 24	14938	6827	8111
25 - 29	24453	11427	13026
30 - 34	20347	10193	10154
35 - 39	14609	7090	7519
40 - 44	11022	5283	5739
45 - 49	8657	4221	4436
50 - 54	8378	4238	4140
55 - 59	6320	2976	3344
60 - 64	6123	2903	3220
65 - 69	4854	2392	2462
70 - 74	4264	1953	2311
75 - 79	3678	1537	2141
80 - 84	2441	862	1579
85 - 89	1436	420	1016
90 and over	669	144	525
Totals	165242	78993	86249

Westminster

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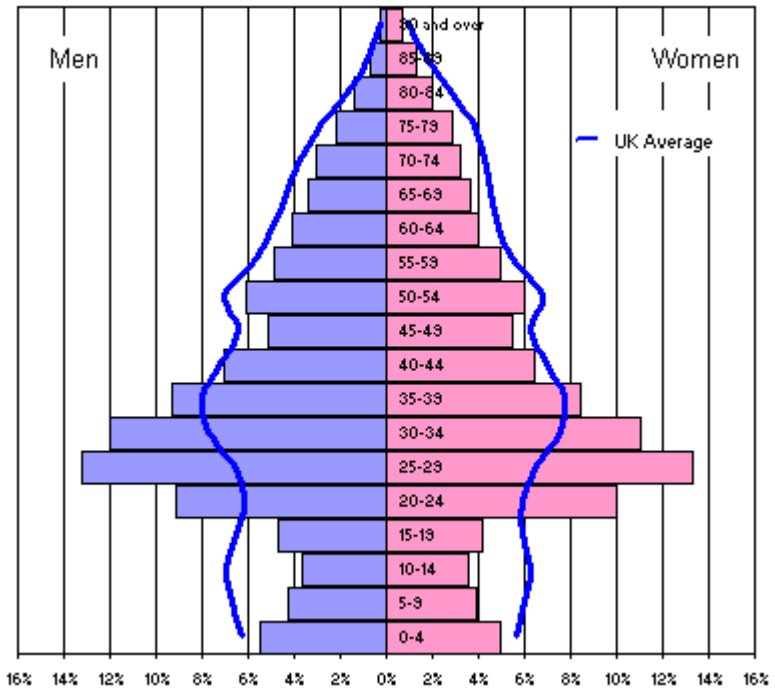

The percentages on the pyramid represent the percentage of 'all males' (to the left) and the percentage of 'all females' (to the right) that are in that age group.

Age Range	Total	Males	Females
0 - 4	9452	4842	4610
5 - 9	7436	3783	3653
10 - 14	6477	3218	3259
15 - 19	8049	4194	3855
20 - 24	17369	8140	9229
25 - 29	24028	11730	12298
30 - 34	20912	10693	10219
35 - 39	16103	8270	7833
40 - 44	12200	6239	5961
45 - 49	9614	4572	5042
50 - 54	10956	5410	5546
55 - 59	8946	4356	4590
60 - 64	7333	3625	3708
65 - 69	6388	3038	3350
70 - 74	5688	2693	2995
75 - 79	4542	1928	2614
80 - 84	3060	1238	1822
85 - 89	1851	612	1239
90 and over	882	226	656
Totals	181286	88807	92479

Wandsworth

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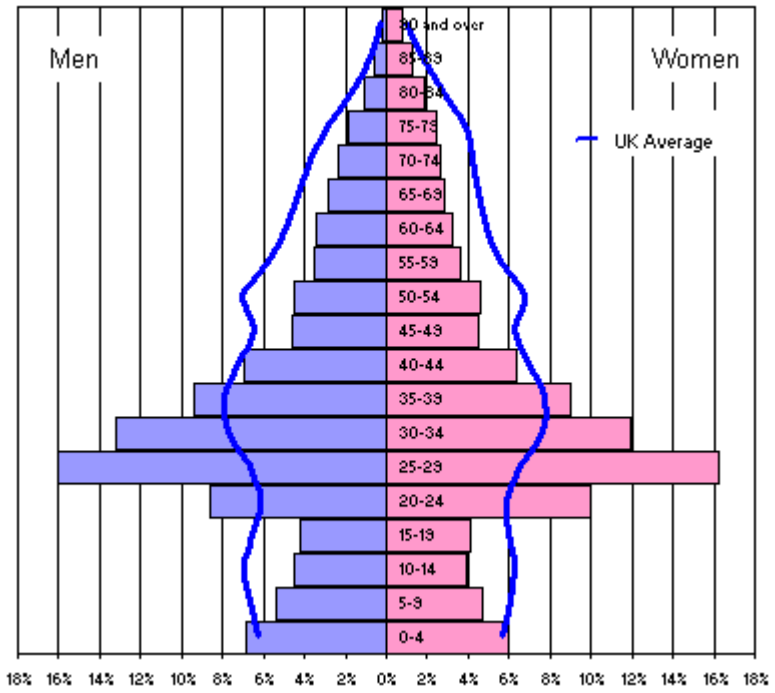


The percentages on the pyramid represent the percentage of 'all males' (to the left) and the percentage of 'all females' (to the right) that are in that age group.

Age Range	Total	Males	Females
0 - 4	16660	8503	8157
5 - 9	13069	6616	6453
10 - 14	10952	5590	5362
15 - 19	10742	5179	5563
20 - 24	24223	10630	13593
25 - 29	42020	19851	22169
30 - 34	32669	16332	16337
35 - 39	23862	11561	12301
40 - 44	17250	8593	8657
45 - 49	11837	5667	6170
50 - 54	11877	5624	6253
55 - 59	9310	4348	4962
60 - 64	8752	4277	4475
65 - 69	7474	3531	3943
70 - 74	6424	2848	3576
75 - 79	5658	2289	3369
80 - 84	3954	1381	2573
85 - 89	2386	671	1715
90 and over	1261	251	1010
Totals	260380	123742	136638

Appendix 9

Data sourced from the Office for National Statistics (last updated Nov 2004)

ETHNICITY	Kensington and Chelsea	Hammersmith and Fulham	Westminster	Wandsworth	London	England
All People (Persons)1	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
White (Persons)1	78.6%	77.8%	73.2%	78.0%	71.2%	90.9%
White: British (Persons)1	50.1%	58.0%	48.5%	64.8%	59.8%	87.0%
White: Irish (Persons)1	3.3%	4.8%	3.6%	3.1%	3.1%	1.3%
White: Other White (Persons)1	25.3%	15.0%	21.1%	10.0%	8.3%	2.7%
Mixed (Persons)1	4.1%	3.8%	4.1%	3.4%	3.2%	1.3%
Mixed: White and Black Caribbean (Persons)1	0.8%	1.2%	0.8%	1.1%	1.0%	0.5%
Mixed: White and Black African (Persons)1	0.7%	0.6%	0.7%	0.5%	0.5%	0.2%
Mixed: White and Asian (Persons)1	1.2%	1.0%	1.3%	0.9%	0.8%	0.4%
Mixed: Other Mixed (Persons)1	1.4%	1.0%	1.4%	0.9%	0.9%	0.3%
Asian or Asian British (Persons)1	4.9%	4.4%	8.9%	6.9%	12.1%	4.6%
Asian or Asian British: Indian (Persons)1	2.0%	1.7%	3.1%	2.8%	6.1%	2.1%
Asian or Asian British: Pakistani (Persons)1	0.8%	1.0%	1.0%	2.1%	2.0%	1.4%
Asian or Asian British: Bangladeshi (Persons)1	0.7%	0.6%	2.8%	0.4%	2.1%	0.6%
Asian or Asian British: Other Asian (Persons)1	1.4%	1.1%	2.0%	1.6%	1.9%	0.5%
Black or Black British (Persons)1	7.0%	11.1%	7.4%	9.6%	10.9%	2.3%
Black or Black British: Caribbean (Persons)1	2.6%	5.2%	3.1%	4.9%	4.8%	1.1%
Black or Black British: African (Persons)1	3.8%	4.9%	3.7%	3.8%	5.3%	1.0%
Black or Black British: Other Black (Persons)1	0.6%	1.1%	0.7%	0.9%	0.8%	0.2%
Chinese or Other Ethnic Group (Persons)1	5.5%	2.8%	6.3%	2.1%	2.7%	0.9%
Chinese or Other Ethnic Group: Chinese (Persons)1	1.6%	0.8%	2.2%	0.9%	1.1%	0.4%
Chinese or Other Ethnic Group: Other Ethnic Group (Persons)1	3.8%	2.0%	4.1%	1.3%	1.6%	0.4%

Appendix 10
The figures are taken from
http://www.londoncouncils.gov.uk/londonfacts/londonstatistics/Householdincomedistributionin200607.htm

London borough	% households with income under 15k	% households with income under 30k	% households with income under 60k
City of London	12	36	72
Barking and Dagenham	30	66	92
Barnet	22	53	85
Bexley	24	57	88
Brent	26	60	89
Bromley	19	50	83
Camden	18	48	81
Croydon	23	55	86
Ealing	23	55	86
Enfield	25	58	88
Greenwich	24	57	87
Hackney	24	57	87
Hammersmith and Fulham	18	47	80
Haringey	23	55	85
Harrow	22	54	86
Havering	24	58	88
Hillingdon	23	56	87
Hounslow	23	56	86
Islington	20	51	83
Kensington and Chelsea	15	42	77
Kingston upon Thames	18	48	81
Lambeth	20	51	83
Lewisham	23	56	86
Merton	20	51	83
Newham	30	65	91
Redbridge	23	56	87
Richmond upon Thames	14	41	76
Southwark	22	54	85
Sutton	21	53	85
Tower Hamlets	23	54	84
Waltham Forest	25	58	88
Wandsworth	17	45	79
Westminster	16	44	78
London average	22	53	85

Appendix 11

Data sourced from the Office for National Statistics (last updated Nov 2004)

SOCIO_ECONOMIC	Kensington and Chelsea	Hammersmith and Fulham	Westminster	Wandsworth	London	England
All People (Persons)1	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
1. Higher managerial and professional occupations (Persons)1	20.3%	17.9%	18.6%	19.5%	12.1%	8.6%
2. Lower managerial and professional occupations (Persons)1	25.8%	26.2%	24.2%	28.0%	22.2%	18.7%
3. Intermediate occupations (Persons)1	5.9%	8.2%	7.2%	9.0%	10.2%	9.5%
4. Small employers and own account workers (Persons)1	7.0%	6.1%	6.0%	5.5%	6.4%	7.0%
5. Lower supervisory and technical occupations (Persons)1	2.8%	3.6%	3.3%	3.6%	5.0%	7.1%
6. Semi-routine occupations (Persons)1	5.7%	6.7%	6.5%	6.7%	9.0%	11.7%
7. Routine occupations (Persons)1	3.7%	4.6%	4.0%	4.2%	5.8%	9.0%
8. Never worked and long-term unemployed (Persons)1	5.7%	5.5%	6.4%	4.2%	6.0%	3.7%
Not Classified (Persons)1	23.1%	21.0%	23.7%	19.3%	23.2%	24.7%

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 18th June 2009

AGENDA ITEM NO.	2.4/Jun/09
PAPER	Open Day 2009 – Evaluation Report
AUTHOR	Matt Akid, Head of Communications
LEAD	Matt Akid, Head of Communications
EXECUTIVE SUMMARY	This paper is an evaluation report of the hospital Open Day held on 9 May 2009.
DECISION/ ACTION	The Members' Council is invited to comment on the evaluation report and to provide any further feedback on the Open Day.

Open Day 2009 – Evaluation Report

1. Introduction

1.1 At its meeting on 19 March 2009 the Members' Council agreed to fund Open Day 2009 at a cost of £15,000.

1.2 **Open Day 2009** was held from **11am-3pm** on **Saturday 9 May**. It was an opportunity for the Trust to place itself at the heart of its community by opening its doors to local people and giving them a chance to become more involved in their local hospital.

1.3 The overall slogan of the Open Day was 'Your hospital, your health, your say'.

2. Aims and themes

2.1 **Aims** of Open Day 2009, as stated in the proposal for funding approved by the Members' Council on 19 March were to:

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

Themes of Open Day 2009, in line with the corporate objectives agreed by the Trust Board in January 2009 were to:

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

3. Implementation

3.1 An Open Day Steering Group provided high level oversight of the Open Day and an Operational Group managed its planning and implementation.

3.2 The Head of Communications was responsible for project managing the Open Day including publicity, logistics, liaison with Trust staff and partner organisations, and organising the official opening of The Kensington Wing.

3.3 A total of 37 Trust teams, 7 charities associated with the Trust and 23 partner organisations took part in the Open Day.

3.4 VIPs who attended the Open Day included 2 local MPs, Sir Malcolm Rifkind and Greg Hands, and the Mayors of both Kensington & Chelsea and Wandsworth, as well as Sophie Ellis-Bextor.

3.5 More than 1,500 visitors attended the Open Day – see section 4 ('Evaluation and feedback') for details.

3.6 Pre-event publicity included:

- Membership mailing to all Foundation Trust members in April including a covering letter from the Chairman and a copy of *Trust News*

- Regularly updated information on the Trust website
- A prominent banner on the front of the hospital
- Flyers and posters distributed widely in the local community
- Targeted mailings for GPs, schools, maternity support groups and others
- Advert in Hammersmith & Fulham Chronicle series of local newspapers (including Kensington & Chelsea News)
- Pre-event editorial coverage in local newspapers, NHS Hammersmith & Fulham's HEALTHeNEWS, Imperial College website and SW6 community website

3.7 Post-event publicity included:

- Photo gallery on Trust website
- Full page of photos in June edition of *Trust News*
- Full page editorial coverage in *Hammersmith & Fulham Chronicle* series of local newspapers (including *Kensington & Chelsea News*)
- Editorial coverage on SW6 community website and Greg Hands MP's website

4. Evaluation and feedback

More than 1,500 visitors attended the Open Day – feedback was sought from both visitors and staff (both Trust staff and those representing charities and partner organisations).

4.1 Visitors' feedback

Open Day visitors were invited to give their feedback by using the new Patient Experience Tracker which will be used to gather instant patient feedback in future – 88% of visitors would recommend the Open Day to friends and family.

See the attached file for full details of visitors' feedback on the Open Day.

4.2 Staff feedback

All staff involved in the Open Day – both those working for the Trust and those from charities and partner organisations that participated – were invited to give feedback either at the post-Open Day meeting on the following Monday or via email. Feedback was largely positive – this is a small representative sample:

Mezino Obonyano (NHS Westminster)
"I thought the day went very well as it was an excellent opportunity to talk to members of the public about what we do, as well as a good opportunity to network with representatives of partner organisations."

Linda Stewart (NHS Kensington & Chelsea)
"It was my day off but I popped in to see my colleagues at the Stop Smoking stand as I live next door. Your event was an absolute success from my point of view as a visitor. It took me about an hour to get to the Stop Smoking stand as there was so much to see and so. Very informative, professional and a lot of fun too!"

Alison Heeralall (Deputy Director of HR)
"It was good to attend as a staff member and to bring family – it always surprises me how much fun it is for even very young kids."

We will analyse all feedback to learn lessons for future events.

5. Funding

The Members' Council agreed to provide £15,000 funding for the Open Day – a checklist of costs paid to date from this budget are provided below (a number of invoices have not yet been received or paid):

Printing (publicity materials etc)	£2,816.11
Furniture hire (tables, chairs etc)	£1,770.89
Balloons	£735
Local newspaper advert	£840.58
T-shirts	£1,732.25
Official photographer	£240
Facepainter	£200
Live music/children's puppet show	£980
Plaque (The Kensington Wing)	£233.45
Staff refreshment vouchers	£2,500
Other expenses	£286.10
Total	**£12,334.38** `

6. Actions for the Members' Council

The Members' Council is invited to comment on the evaluation report and to provide any further feedback on the Open Day.

Matt Akid
Head of Communications
June 2009

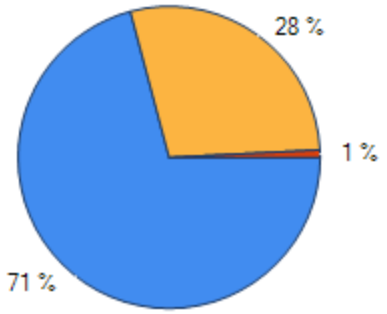
Patient Feedback Report

Period: 09 May 09 to 09 May 09

Dr Foster - NHS - "Open day" 2009

Response Volume	127	Overall Score	92.5

How would you rate the Open Day?

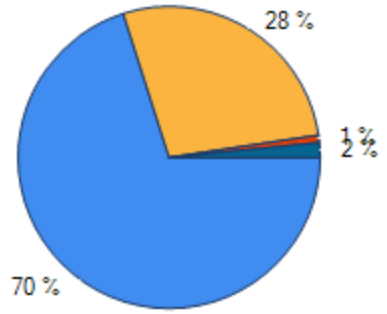


Did you find the information stands informative?

Were the staff friendly and approachable?

Would you recommend the Open Day to friends and family?

Did you find everything you were looking for?



CFS EUROPE

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 18th June 2009

AGENDA ITEM NO.	2.5/Jun/09
PAPER	Annual Members' Meeting 2009 - Proposal
AUTHOR	Matt Akid, Head of Communications
LEAD	Professor Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This is a proposal for the Annual Members' Meeting to be held on Thursday 17 September.
DECISION/ ACTION	The Council is invited to comment on this proposal to help shape plans for the Annual Members' Meeting.

ANNUAL MEMBERS' MEETING 2009 – PROPOSAL

1. Background

The Annual Members' Meeting will be held at **5.30pm** on **Thursday 17 September** in the Restaurant on the lower ground floor of the hospital.

In previous years this has been a well-attended event with several hundred Foundation Trust members and hospital staff in attendance.

Our Foundation Trust constitution sets the following requirements for the meeting:

- The Board of Directors shall present to Foundation Trust members the annual report and accounts; report of the external financial auditor (included in the annual report and accounts); forward planning information for the next financial year (ie 2009/10)
- The Members' Council shall present to Foundation Trust members a report on steps taken to ensure that the membership of the Trust is representative of those eligible for membership of the public, patients and staff constituencies; progress on the membership strategy; results of Members' Council elections; announcement of any Non-executive Directors appointed

2. Members' Council involvement

Planning for this year's Annual Members' Meeting is at any early stage because the event is in 3 months' time. However, the Members' Council is asked for its involvement in planning at this stage because the next full Council meeting will not be held until the day of the Annual Members' Meeting.

Comments will be incorporated into the Trust's planning and implementation and there is also scope for further discussion at the the Membership Development & Communications Sub-Committee on 25 August.

3. Aims and themes

3.1 Aims

A key aim of the Annual Members' Meeting is to create a positive event which enables the Board and the Members' Council to set out the key achievements of the last financial year and plans for the current financial year.

The meeting should also aim to create a genuine dialogue with Foundation Trust members by providing them with an opportunity to ask questions of the Board of Directors and to provide their feedback on the Trust's performance and future plans.

3.2 Themes

It is proposed that the overarching theme of the Annual Members' Meeting should be 'Your hospital, your health, your say' to ensure consistency with the Open Day.

It is also proposed that improving the patient experience – which is among the Trust's 3 corporate objectives for 2009/10 – should be a unifying theme of presentations by speakers at the Annual Members' Meeting.

Examples of Trust initiatives to improve the patient experience could include:

- Patient Experience Tracker to get 'real time' feedback from patients
- The formation of a Patients' Panel to track the views of patients on key issues

- Annual Patient Survey and the Trust's action plan in response
- Trust response to the Kensington & Chelsea Residents' Panel on healthcare

For decision

- The Members' Council is invited to comment on the proposed aims and themes of the Annual Members' Meeting

4. Format of the meeting

4.1 Statutory presentations (5-10 minutes maximum for each speaker):

1. Chairman
Introduce 'Your hospital, your health, your say' theme. Use examples of engagement with Foundation Trust members, the Members' Council and others in the local community, for example the Open Day, stroke campaign, specialist paediatrics bid etc. Use examples of patient-centred service developments, for example 56 Dean Street and CLAHRC. Use our new Quality Report as an example of how the Trust is prioritising care improvements for patients – and how we will be held to account.

2. Chief Executive
Build on this introduction by outlining our performance in 2008/09 and our plans for 2009/10 both operationally and strategically. Focus on key issues for the public including quality of care, waiting times, infection control/cleaning, hospital food etc. Explain how we are planning financially to survive the economic downturn without compromising the quality of care.

3. Director of Finance
Presentation of accounts and brief overview of our financial position, in particular how we have used our Foundation Trust freedoms to invest our 2008/09 surplus in developments to improve patient care.

4. Members' Council representatives
Membership report to include an explanation of the role of the Members' Council and inviting Foundation Trust members to stand for election in October.

For decision

- The Members' Council is invited to comment on the proposed content of the statutory presentations
- Members' Council representatives are invited to indicate if they are interested in presenting the membership report at the Annual Members' Meeting

4.2 Optional DVD screening (10 minutes maximum):

Following the success of screening an ITN film about the hospital at last year's Annual Members' Meeting, it is proposed to screen the DVD developed with the help of funding by the Members' Council for children coming into hospital. This is a good example of how the Trust is helping to improve the patient experience in Paediatrics and it also demonstrates how the Members' Council supports the Trust.

For decision
The Members' Council is invited to comment on the proposal to screen the DVD

4.3 Votes on changes to the Foundation Trust constitution

A number of votes on constitutional issues may be necessary (see agenda item 2.8 – Review of constitutional items).

If votes are required, full details will be included in both the Foundation Trust membership mailing which is sent out to publicise the Annual Members' Meeting in August and also the agenda/programme provided at the meeting itself.

4.4 Q&A
At least half of the meeting to be left for questions from the public to be answered by the Trust Board of Directors.

5. Possible events associated with the Annual Members' Meeting

The Annual Members' Meeting is held at a time of day and is required by statute to follow a format which is unlikely to appeal to women who are current users or recent users of our Maternity services or children and their families who are users of our Paediatric services.

It is proposed to explore the possibility of running focus groups or similar engagement opportunities targeted at these 2 key audiences – in line with the Trust's strategic aim of being a centre of excellence for women's and children's health.

If these events were held 7-10 days prior to the Annual Members' Meeting, feedback could be displayed on screens at the meeting and the Trust Board could respond to the feedback.

For decision
The Members' Council is invited to suggest how best the Trust could engage with these key audiences

6. Actions for the Members' Council

The Members' Council is invited to comment on this overall proposal for the Annual Members' Meeting and associated events.

Matt Akid
Head of Communications
June 2009

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 18 June 2009

AGENDA ITEM NO.	2.6/June/09
PAPER	Membership Report
AUTHOR	Dianne Holman, Interim FT Secretary
LEAD	Dianne Holman, Interim FT Secretary
EXECUTIVE SUMMARY	This report provides details of: a) 2008/09 – Historical Analysis; and b) 2009/10 – Highlights
DECISION / ACTION	The meeting is invited to review performance in developing local accountability and growing a representative membership.

MEMBERSHIP REPORT 2008/09 – Historical Analysis

MEMBERSHIP REPORT

Membership size and movements

	Last Year 2008-09	Next Year (estimated) 2009-10
Total Membership		
At year start (1 April)	13,140	15,438
New Members	3,104	1,086
Members Leaving	806	779
At year end (31 March)	**15,438**	**15,745**

Representing:

Public Constituency		
At year start (1 April)	6,580	6,372
New Members	195	436
Members Leaving	403	436
At year end (31 March)	**6,372**	**6,372**

Patient Constituency		
At year start (1 April)	6,095	6,136
New Members	433	650
Members Leaving	392	343
At year end (31 March)	**6,136**	**6,443**

Staff Constituency		
At year start (1 April)	465	2,930
New Members	2,476	0
Members Leaving	11	0
At year end (31 March)	**2,930**	**2,930**

Public constituency	Number of members	Eligible Membership
Age(years):		
0 - 16	1	127,076
17 - 21	66	41,156
22+	5,461	771,257
Unknown	844	
At year end (31 March)	**6,372**	**939,489**
Ethnicity:		
White	4,556	589,219
Mixed	245	29,013
Asian or Asian British	342	49,221
Black or Black British	280	68,025
Other	309	204,011
Unknown	640	
At year end (31 March)	**6,372**	**939,489**
Socio-economic groupings:		
ABC1	5,528	598,056
C2	2	
D	0	43,873
E	829	
Unknown	13	297,560
At year end (31 March)	**6,372**	**939,489**
Gender:		
Male	2,550	367,501
Female	3,779	398,326
Unknown	43	173,662
At year end (31 March)	**6,372**	**939,489**

Patient constituency	Number of members	Eligible Membership
Age(years):		
0 - 16	1	46,000
17 - 21	64	24,000
22+	6,071	448,000
At year end (31 March)	**6,136**	**518,000**

Analysis of election turnout

Date of election	Constituencies Involved	Number of members in constituency	Number of seats contested	Number of contestants	Election turnout %
24/08/2008	Kensington & Chelsea Area 2	2029	1	3	15.8%

MEMBERSHIP COMMENTARY

The total membership of the Trust was 15,438 members at 31st March 2009 drawn from public, patient and staff constituencies, each having its own eligibility rules though all members are required to be at least sixteen (16) years old.

Constituencies and commentary on changes in membership numbers

Overall, the membership grew by 18% in 2008-09 falling short of the target of 20%.

Public constituency
Public members must live in one of the four neighbouring boroughs: Kensington & Chelsea; Hammersmith & Fulham; Wandsworth; or Westminster.

The target growth for this constituency in 200-09 was 0%; however, there was negative growth in this constituency as recruitment did not match leavers.

Patient constituency
Patient members must be patients of the hospital within the last three years or carers of such patients.

The patient's constituency was planned to grow by 5% in 2008-09 in line with recruitment. Actual growth realised was 0.7%.

Staff constituency
The staff constituency is open to both employees (subject to the requirement to hold a contract of either no fixed term or for a minimum of 12 months or to have been continuously employed for 12 months) and other individuals who continually exercised functions for the purposes of the Trust for at least 12 months.

The target growth rate for 2008-09 was 496% based on changing the constitutional provisions to a default position of automatic membership. The actual growth was 530%, the number of members opting out was minimal and the Trust exceeded its target for this constituency.

Target Levels of Representation

The Trust also addresses qualitative factors and the need for membership of the public constituency to be representative of the communities which it serves. The Members' Council development & Communications Sub-Committee have identified three (3) areas for further development:

Geographical
Penetration in the Wandsworth One sub-constituency was significantly below the benchmark of 1% of the local population. This includes the catchment area of Earlsfield, Fairfield, Roehampton, Southfields, Thamesfield, Tooting, Wandsworth Common, Westhhill and West Putney.

Age
The distribution of the membership in the under-40 age group was significantly lower than the general population; however, the trend reversed past the age of 40.

Socio-Economic Groups

Based on profiling by postcode, the distribution of the Trust's membership is significantly higher in the lowest social group than in the general population and is significantly lower in the highest social group.

Review by Board of Directors

The Chairman of the Board of Directors presents a monthly report to the Board setting out a table showing the changes in the membership of each constituency along with a narrative commentary. The Chairman (who also chairs the Members' Council) through his monthly report keeps the Board of Directors informed about the work of the Members' Council and its sub-committees in relation to growth and engagement, among other matters.

Steps taken in the last twelve months

In developing the Annual Plan for 2008-09, it was recognised that costs of recruitment had been under-estimated in previous years and a number of initiatives had been agreed to secure target growth rates. These included:

a) Developing leaflets and display stands in line with the Chelsea & Westminster brand;
b) Two (2) week long recruitment campaigns in advance of Open Day and the Annual Members' Meeting;
c) Development of an 'Information Zone' with a 60-inch plasma screen and electronic kiosks; and
d) An application form in discharge booklets.

A generous proportion of the Members' Council budget was allocated to projects to promote membership development and communications in support of the Annual Plan.

Steps planned in the next twelve months

The Trust's targets for 2009-10 are set not in relation to local population benchmarks, rather in relation to actual achieved growth in 2008-09. The Trust is operating in a rapidly-changing provider environment with a risk of a severe down turn in public finances. Recruitment must be constrained by value-for-money considerations.

The Trust will focus in 2009-10 on achieving sustainable growth and will focus on the retention of existing members as well as the recruitment of new ones.

The most critical challenge is the public constituency where the default method of joining is opt-in. Our public constituency benchmark is 9,395 members in keeping with 1% the ONS resident population estimates for mid-2005. The Trust does not believe that it can significantly increase numbers in the public constituency over a three-year term as this will overwhelm the operational and financial capacity of the Trust. Benchmarking over a three-year period will require recruitment of more than 1,333 public members in the 2009-10 financial year compared to 195 new members recruited in the year under review.

The Trust's target is to maintain the size of the membership in the public constituency in 2009-10. There are now more Foundation Trusts in London competing for members and it is now much more difficult and costly to recruit new members.

In the patient constituency, the Trust aims for growth of 5% through the continued use of its new discharge leaflet which was developed in late 2008. The feedback received is that this method has been successful and the Trust will attempt to ensure that every patient discharged receives a leaflet. The Trust expects to see the full-year effect of this method in 2009-10.

The Trust embarked on a number of initiatives in the year under review to develop its branding and engage its membership and expects to see the rewards in 2009-10 when it completes the development and refurbishment of its Information Zone within the hospital in 2009-10. This will become a dedicated area equipped with electronic kiosks to promote communication with members.

The Trust is recruiting a dedicated Engagement and Membership Manager in June 2009 with responsibility for developing the communications and engagement strategy. The Trust will also use its Seasonal Working Conferences, Patients' Panels and links with the Patient Advice and Liaison Service to network and develop the membership.

The Trust will also continue to promote two week-long membership recruitment campaigns which usher in Open Day and the Annual Members' Meeting.

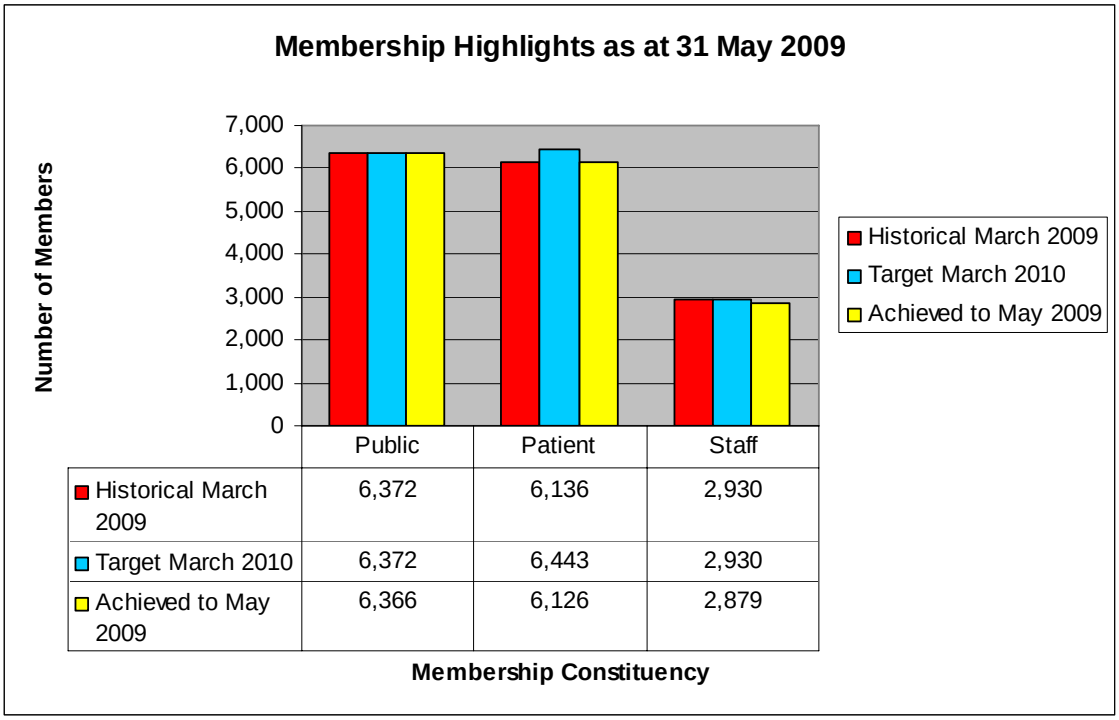
Approximately 60% of Council Members seats will become vacant in the autumn as some of the original Council Members come to the end of their term. The election will be an opportunity for the Trust to generate another wave of interest in membership when it invites nominations for the various vacant seats in the autumn. The Trust will encourage nominees who are able and willing to network in their communities and support its newly-elected Council Members by means of a comprehensive induction in articulating the case for a representative membership.

Elections

In the last year, 2008-09, an election was conducted in accordance with the rules of the constitution in the public constituency Kensington & Chelsea Area Two to fill the seat vacated by Valerie Arends. Lady Sandra Smith-Gordon was elected. The turnout was 15.8%.

2009/10 – Highlights

Membership



	Public	Patient	Staff
Historical March 2009	6,372	6,136	2,930
Target March 2010	6,372	6,443	2,930
Achieved to May 2009	6,366	6,126	2,879

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 18 June 2009

AGENDA ITEM NO.	2.7/June/09
PAPER	Funding Report
AUTHOR	Dianne Holman, Interim FT Secretary
LEAD	Dianne Holman, Interim FT Secretary
EXECUTIVE SUMMARY	This report provides details of: 2008/09 – Historical Analysis and 2009/10 – Highlights and proposals for further allocations.
DECISION / ACTION	The meeting is invited to review spend and agree allocations for 2009/10.

FUNDING REPORT 2008/09 – Historical Analysis

Activity	Total
Brand Development	10,194
Screens and related software	19,745
Interior refurbishment of Information Zone (accrued)	15,079
Re-design of recruitment leaflets	5,683
Joint Away Day	4,169
Internet Diagnostic	7,134
Discharge Leaflet	8,200
Membership Weeks	5,148
One-off Mailing	4,540
Paediatric DVD	20,108
Total	100,000

A generous proportion of the Members' Council budget was allocated to projects to promote membership development and communications in support of the annual plan. It is useful to look at these costs in terms of retention of existing members and recruitment of new ones:

1) The Information Zone (£34,824), the website diagnostic work (£7,134) and the one-off mailings (£4,540) were intended to benefit both existing and new members and the cost was approximately £3.71 for each of the 12,508 existing public and patient members.

2) The direct cost of recruiting new members via campaigns (£5,148) and recruitment materials (£24,077) was far higher at £175.00 for each of the 167 incremental patient and public members recruited.

FUNDING REPORT 2009/10 – Highlights

Funding

Item	Estimates (excl VAT)	Actual (Excl VAT)
Annual budget 09-10	100,500	100,500
Accrued 08/09 for approved expenditure	15,079	14,828
Information Zone seating, screen & wing art	-16,085	-16,236
Information Zone Security Kiosk move	-305	-305
Recruitment Campaign for Open Day	-2,574	-1,791
Open Day	-15,000	-12,334
Residual Budget 09-10	**81,615**	**84,662**
Less Agreed Allocation		
Information Zone Security Frame to TV, Kiosk move, contingency, Project Management Fees	-3,763	
Recruitment Campaign for Annual Members' Meeting	-2,574	
Discharge Leaflets	-8,200	
Unallocated Budget	**67,078**	

Further Funding Proposals 2009/10

Directory of Services

Following the positive response to the Paediatric Survey Directory, GPs have expressed their demand for an equivalent directory for the Trust's adult services. In a recent GP survey, 87% of GPs said they would find a Directory of the hospital's adult services useful. It is therefore proposed that a Directory of Services is developed to complement the Directory of Children's Services. The objectives of the Directory would be as follows:

- Promote the hospital's services to GPs
- Reduce inappropriate referrals and referral methods
- Reduce basic queries to the hospital (which clinics we run etc)
- Improve the relationship with local GPs

The budget for the project would be:

- Writing fee - £6,000
- Design costs - £3,080
- Print run (4000 copies) - £7,239.25
- Total cost: £16,319.25

These costs are based on an 84 page leaflet, but if any additional pages are required the cost of the project will increase. A contingency of £3,500 will therefore be included in the budget to allow for these additional costs.

The total budget for the project is therefore £19,817.

The Members' Council is asked to consider the allocation of £19,817 for the directory of Services and to suggest any further uses of the budget allocation for consideration.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Quarterly Meeting
18 June 2009

AGENDA ITEM NO.	2.8/May/09
PAPER	Review of Constitutional items
AUTHOR	Dianne Holman, Interim FT Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	This paper deals with two areas which are provided for by constitution. a) The title of the Members' Council b) Arrangements for membership: persons exercising functions at the Trust
DECISION / ACTION	The meeting is asked to take decisions as appropriate a) To agree on title for the Members' Council b) To agree constitutional change proposed

A. Title of Members' Council

1.0 Background

A few Council Members have expressed their preference for changing the title 'Members' Council' to an alternative.

A few reasons have been put forward for consideration:

- The substantial majority (114/121) uses 'Governors' in the title of the body; so does Monitor and the Foundation Trusts' Governors Association.
- Many people do not know what a Members' Council is.
- The title 'governors' is not confusing.

The original decision on the terms 'Council Members' and 'Members' Council' was made prior to authorisation as an FT in 2006 and has been incorporated in the Trust's Constitution. Any subsequent amendments would require approval of a majority of members voting at a members' meeting and the independent regulator, Monitor.

2.0 Historical Perspective

The decision was made to avoid confusion in the public perception of the role of this body. The term 'governor' is well understood by the public in the context of the Board of Governors of schools. The role of school governors includes:

- setting strategic direction, policies and objectives
- approving the school budget
- reviewing progress against the school's budget and objectives
- appointing, challenging and supporting the headteacher

The responsibilities of school governors are much more closely aligned to that of the Board of Directors.

3.0 View of the Board of Directors

The views of the Board of Directors were sought to inform the discussion. The Directors felt that that the term 'Members' Council' continues to be relevant and avoids any unnecessary ambiguity over the public perception of the complementary roles of the two main organs of the Trust. It also emphasises our philosophy of inclusion and democracy. Further, it was noted that, as a consequence of such a change

- the Trust would incur substantial costs to re-produce materials and literature, e.g. the Constitution, recruitment leaflets, discharge booklets, website content, and it would not be prudent at this time against the backdrop of the economic downturn; and

- There would be a number of residual documents published over the last three years containing the term ‘Members’ Council’ which would lead to confusion unless additional work is undertaken to ensure that the membership and public understand the change.

4.0 Other NHS Trust Hospitals names for Council/Governors (June 8 2009)

A list of the range of titles used by FTs has been complied at Appendix 1 for information.

5.0 Action

The Members’ Council is asked for their views on changing the title ‘Members’ Council’ and ‘Council Member’.

Other NHS Trust Hospitals names for Council/Governors (June 8 2009)

Information from Monitor web site [www.monitor-nhsft.gov.uk/] on all 121 NHS Trusts
(research by Sandra Smith-Gordon)

2Gether	Council of Governors
Aintree U Hospitals	Board of Governors
Alder Hey Children's	Council of Governors
Barnsley Hospital	Governing Council
Basildon & Thurrock U Hospitals	Board of Governors
Basingstoke & N Hampshire	Council of Governors
Berkshire Healthcare	Council of Governors
Birmingham & Solihull Mental Health	Governors
Birmingham Children's	Council of Governors
Birmingham Women's	Governors
Blackpool, Fylde & Wyre	Council of Governors
Bradford Teaching	Board of Governors
Burton Hospitals	Council of Governors
Calderdale & Huddersfield	Membership Council/Council Members
Calderstones Partnership	Board of Governors
Cambridge U Hospitals	Board of Governors
Cambridgeshire & Peterborough	Governors
Camden & Islington	Governors
Central & NW London	Governors
Central Manchester U Hospitals	Council of Governors
Chelsea & Westminster	Members Council/Council Members
Cheshire & Wirral Partnership	Governors
Chesterfield Royal	Council of Governors
City Hospitals Sunderland	Board of Governors
Clatterbridge Centre for Oncology	Council of Governors
Colchester Hospital University	Members Council/Governors
Countess of Chester	Board of Governors
County Durham & Darlington	Governing Council/governors
Cumbria Partnership	Governing Council/governors
Derby	Council of Governors
Doncaster & Bassetlaw	Governors
Dorset County	Council of Governors
Dorset Healthcare	Council of Governors
Dudley Group	Council of Governors
East Kent Hospitals University	Council of Governors
East London	Members Council/Council Members
Frimley Park	Council of Governors
Gateshead Health	Council of Governors
Gloucestershire Hospitals	Council of Governors
Great Western Hospitals	Council of Governors
Greater Manchester West Mental Health	Council of Governors
Guy's & St Thomas'	Council of Governors
Hampshire Partnership	Council of Governors
Harrogate & District	Board of Governors
Heart of England	Governors Consultative Council/governors
Heatherwood & Wexham Park	Council of Governors
Hertfordshire Partnership	Board of Governors

Homerton U Hospital	Council of Governors
James Paget U Hospitals	Governors Council
Kettering General Hospital	Members Council/Council Members
Kings College Hospital	Board of Governors
Lancashire Care	Council of Governors
Lancashire Teaching Hospitals	Governing Council
Leeds Partnerships	Board of Governors
Lincolnshire Partnership	Board of Governors
Liverpool Women's	Council of Governors
Luton & Dunstable	Council of Governors
Medway	Council of Governors
Mid Cheshire Hospitals	Council of Governors
Mid Staffordshire	Council of Governors
Milton Keynes Hospitals	Members Council/Councillors
Moorfields Eye Hospitals	Membership Council/Governors
Norfolk & Norwich U Hospitals	Council of Governors
Norfolk & Waveney Mental Health	Board of Governors
North East London	Council of Governors
North Essex Partnership	Council of Governors
North Tees & Hartlepool	Council of Governors
Northamptonshire Healthcare	Board of Governors
Northern Lincolnshire & Goole	Council of Governors
Northumbria Healthcare	Governors Body
Oxfordshire & Buckinghamshire Mental Health	Members Council/Governors
Oxleas	Council of Governors
Papworth Hospital	Board of Governors
Pennine Care	Council of Members/Councillors
Peterborough & Stamford Hospitals	Board of Governors
Poole Hospital	Council of Governors/Elected Representatives
Queen Victoria	Board of Governors
Rotherham, Doncaster & South Humber Mental Health	Council of Governors
Royal Berkshire	Council of Governors
Royal Bolton Hospital	Council of Governors
Royal Brompton & Harefield	Governors Council
Royal Devon & Exeter	Council of Governors
Royal National Hospital for Rheumatic Diseases	Council of Members/Governors(patient & public)/Representatives(staff & partner orgs.)
Salford Royal	Council of Governors
Salisbury	Council of Governors
Sandwell Mental Health & Social Care	Assembly of Governors
Sheffield Children's	Council of Governors
Sheffield Health & Social Care	Council of Governors
Sheffield Teaching Hospitals	Governors Council
Sherwood Forest Hospitals	Board of Governors
Somerset Partnership	No information on website
South Devon Healthcare	Governance Board/Governors
South Essex Partnership University	Board of Governors
South London & Maudsley	Members Council
South Staffordshire & Shropshire Healthcare	Membership Council/Governors
South Tees Hospital	Council of Governors
South Tyneside	Board of Governors
South West Yorkshire Partnership	Members Council/Representatives

Southend University Hospital	Board of Governors
Stockport	Board of Governors
Surrey & Borders Partnership	Council of Governors
Sussex Partnership	Council of Governors
Tameside Hospital	Council of Members
Taunton & Somerset	Members Council/Governors
Tavistock & Portman	Board of Governors
Tees, Esk & Wear Valleys	Council of Governors
The Christie	Council of Governors
The Newcastle Upon Tyne Hospitals	Council of Governors
The Rotherham	Council of Governors
The Royal Bournemouth & Christchurch Hospitals	Council of Governors
The Royal Marsden	Membership Council/Councillors
The Royal Orthopaedic Hospital	Members Council/Governors
University College London Hospitals	Governing Body
University Hospital of South Manchester	Council of Governors
University Hospitals Birmingham	Board of Governors
University Hospitals Bristol	Membership Council/Governors
Warrington & Halton Hospitals	Governors
Wirral University Teaching Hospital	Assembly of Governors
Wrightington, Wirral and Leigh	Council of Governors/Representatives
Yeovil District Hospital	Board of Governors
York Hospitals	Members Council/Governors

	Group name	**Individuals name**
2	Assembly of Governors	
25	Board of Governors	
53	Council of Governors	
1	Council of Governors	Elected representatives
1	Council of Governors	Representatives
1	Council of Members	
1	Council of Members	Councillors
1	Council of Members	Governors (patient & public) Representatives (staff & partner orgs)
1	Governance Board	Governors
1	Governing Body	
2	Governing Council	
2	Governing Council	Governors
8	Governors	
1	Governors Body	
1	Governors Consultative Council	Governors
3	Governors Council	
1	Members Council	
3	Members Council	Council Members
1	Members Council	Councillors
5	Members Council	Governors
1	Members Council	Representatives
1	Membership Council	Council Members
3	Membership Council	Governors
1	No information	

7/121 (5.7%) do not have governors in their name

Monitor uses the term Governors

See also Foundation Trusts' Governors Association

B. Review of arrangements for membership: persons exercising functions at the Trust

Background

In October 2008, the Trust received authorisation from Monitor to revise its constitution to enable a system of automatic membership by default for all members of the staff constituency. This means that an individual can become a member without an application being made.

This applies to individuals who, though not employed by the Trust, have nevertheless continuously exercised functions for the purposes of the Trust for at least 12 months. This is defined in the constitution.

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Risk

In addition to staff directly employed by us there are a number of other staff groups who potentially meet the criteria above (i.e. if continuously exercised functions for the purposes of the Trust for at least 12 months). These include volunteers, and staff working for organisations such as charities e.g. Chelsea and Westminster Health Charity, ISS, Balfour Beatty, Imperial Healthcare, Olympic Transport, Imperial College, agency and bank staff.

In order for the Trust to comply with 'opt out' for these individuals the Trust needs information from the third parties who employ the staff described above to determine the eligibility of these individuals for the purpose of the statutory register of members required to be kept in accordance with the constitution.

If this information is supplied, the Trust is unable to validate the completeness, accuracy, timeliness, relevance or reliability of the information provided by third parties. Therefore the Trust risks non-compliance with its constitution by:

- Failing to register eligible members in the staff constituency;
- Failing to remove members in patient or public constituencies who do not continue to remain eligible; and
- Registering members in the staff constituency who are ineligible for membership.

Magnitude & Likelihood

The Trust assesses this risk as applying to a small number of individuals drawn from the wide range of external charitable, educational, research and healthcare organisations in North West London, identified above and possibly private-sector commercial organisations.

The Trust is not yet in a position to prepare an exhaustive list of all the organisations or third parties to which eligible members may belong in order to register members but is working through the scope and practical implications of the constitution's revision and has so far identified approximately 20 relevant organisations.

Proposal

The Members' Council Sub-Committee for Membership Development and Communications reviewed this risk at its meeting in May 2009 and proposed, for the approval of the Members' Council, an amendment to the Constitution to require a membership application to be made by individuals who, though not employed by the Trust, have nevertheless continuously exercised functions for the purposes of the Trust for at least 12 months (i.e. opt out does not apply to these individuals, they must apply to be a member).

The effect would be a compromise as the Trust could comply with its statutory obligations while volunteers would not be barred from membership on the basis that they were not eligible to join in the public or patients' constituency as was the case in the past.

Approval of a majority of members present and voting at a members' meeting as well as approval of a majority of members of the staff constituency voting at a members' meeting is required for this amendment.

Action
The Members' Council is asked to agree the constitutional amendments proposed for a vote at the Annual Members' Meeting in September 2009.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Quarterly Meeting
18 June 2009

AGENDA ITEM NO.	2.9/May/09
PAPER	Policy for Board Composition of Non-Executive Directors
AUTHOR	Dianne Holman, Interim FT Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	The Trust's Constitution at section 12.5.1 provides *'The Members' Council will maintain a policy for the composition of the non-executive directors which takes account of relevant Trust strategies, and which they shall review from time to time and not less than every three years'.* The Trust was authorised in October 2006 and a formal review of the policy is now required. No formal policy is in force and the attached draft is proposed for consideration. It is also proposed that, in future, the Nominations Committee will review this policy and make recommendations to the Members' Council. (This is covered in paper 2.10 on today's Agenda.)
DECISION / ACTION	The Members' Council is asked to agree the draft policy.

Members' Council

DRAFT Policy for Board Composition of Non-Executive Directors

The purpose of this policy is to ensure that the non-executive branch of the board of Directors is composed of persons who are collectively fit and proper to direct the Trust's business with prudence, integrity and professional skills.

1.0 ELIGIBILITY

The Trust's constitution provides that a Non-Executive Director must be a member of one of the Trust's public or patient constituencies, or an individual exercising functions for Imperial College, University of London in order to be eligible for appointment.

A Non-Executive Director should also not be disqualified under any of the provisions of section 12.8 of the Constitution.

2.0 COMPOSITION

2.1 Size

The Trust's constitution provides for a Chairman and five (5) other non-executive directors, all of whom are appointed (and removed) by the Members' Council at a General Meeting.

2.2 Independence

A substantial majority of the seated Non-Executive Directors will be independent, in accordance with the standards of the Constitution for conflict of interests, the NHS Code of Governance and extant International Financial Reporting Standards adopted by the Trust.

2.3 Role of Vice-Chairman

There shall be a Vice-Chairman elected by the Board from its non-executive directors to take on the Chairman's duties if the Chairman is absent from the meeting or is otherwise unavailable or unable to discharge his office as Chairman.

2.4 Role of Senior Independent Director

There shall be a Senior Independent Director (SID) appointed by the Board to act as an independent point of contact for the Board of Directors and the Members' Council.

2.5 Attributes

The attributes required for non-executive directors including personal qualities, behavioural skills, strategic skills, knowledge and previous experience shall be determined by the Board of Directors, taking into account the Trust's strategies.

2.6 Time Commitment

The time commitment required of non-executive directors including evenings, reading, events, committee meetings, preparatory work and travel shall be determined by the Board of Directors.

3.0 APPOINTMENTS

It is the responsibility of the Nominations Committee to identify appropriate candidates (not more than five for each vacancy) through a process of open competition which takes account of the policy maintained by the Members' Council and the skills and experience identified by the Board of Directors and make recommendations for the successful candidate to the Members' Council.

4.0 RE-APPOINTMENTS

4.1 Pre-requisites

The Trust's Constitution requires that the re-appointment of a Non-Executive Director by the Members' Council shall be subject to satisfactory appraisal carried out in accordance with procedures which the Board has approved.

4.2 Disclosures

Where a Non-Executive Directors seeks re-appointment, he/she will be required to inform the Members' Council of any changes in employment responsibilities; the ability to attend meetings and fully participate in the activities of the Board; and whether the director has developed any relationships with the Trust or another organisation, or other circumstances have arisen, that might make it inappropriate for the director to continue serving on the Board.

4.3 Retirement from Board

There is no upper age limit for serving on the Board.

5.0 COMPENSATION

The Members' Council sets the terms and conditions of office. The Members Council is aware that all money paid to non-executive directors is taxpayers' money and ensures that value for public money is obtained.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 18 June 2009

AGENDA ITEM NO.	3.1/Jun/2009
PAPER	Finance Report – March 2009
AUTHOR	Neil Callow, Deputy Director of Finance
LEAD	Lorraine Bewes, Executive Director of Finance
EXECUTIVE SUMMARY	Subject to finalisation of statutory accounts and external audit, the Trust has delivered a maximum 5 Financial Risk Rating. The Trust is reporting a £9.63m income and expenditure surplus for the 12 months to 31st March 2009 (£1.66m above plan). This is also £0.11m ahead of the previous forecast outturn reported to the Board. The current month's performance shows an income and expenditure surplus of £0.19m which is ahead of the plan by £0.47m. However it is important to note that although it is positive to have delivered a surplus against plan, a higher surplus should have been expected noting: - increased income of £11.7m above plan - release of £3.78m balance sheet provisions offset by £0.72m exceptional costs £5.44m (80%) of the £6.76m annual savings requirement has been delivered. The Trust cash position in the month is £32.05m which is ahead of the Monitor plan by £15.28m. The main elements of this are carry forward of capital programme projects (£19m) and the Trust has received £3.1m cash towards the Burns capital development. However this is partially offset by not drawing down the loan of £6.75m for Specialist Paediatrics included in the Monitor cash flow plan. Capital Budgets are overall overspent by £1.28m, the largest element as a result of the Charity contributing £0.60m less than anticipated towards the second CT scanner.
DECISION/ ACTION	The Members' Council is asked to note the financial position for the period to 31st March 2009 and the updates in this report.

Financial Summary to March 2009

1. Introduction

1.1. This paper sets out the financial position for the 12 month period to 31st March 2009.

2. Overall Financial Position (Form F1)

2.1 The income and expenditure position to the end of March is a surplus of £9.63m, which is £1.66m ahead of plan. Current month performance shows a surplus of £0.19m, which is a surplus of £0.47m against plan.

	Year to 31st March 2009			
	Budget £'m	Actual £'m	Variance £'m	% Var
Income	269.0	280.7	11.7	4.3%
Expenditure	244.9	254.2	-9.3	-3.8%
EBITDA	24.1	26.5	2.4	
EDITDA Margin %	9.0%	9.5%		
Interest, Dividends and Depreciation	16.1	16.9	-0.8	
Surplus/Deficit (-ve)	8.0	9.6	1.7	

2.2 A Financial Risk Rating of 5 has been delivered as shown in the following table:

	Value	Rating	Weighting
Achievement of Plan %	110%	5	10%
EBITDA Margin %	9.50%	4	25%
Net Surplus Margin %	3.40%	5	20%
Return on Assets %	6.20%	5	20%
Liquidity Days	49.2 days	5	20%
Overall Score		**5**	

2.3 Although the Trust was ahead of plan, it is important to note that there are a number of non-recurring items underpinning this position. The following table confirms an underlying shortfall against plan of £1.41m when these exceptional items are adjusted for.

	Current Month £000s	Year to Date £000s
Reported surplus / (deficit) against plan as at 31/03/09	**466**	**1,660**
Release of Provision	0	(3,784)
Exceptional items		
Maternity Patient Experience Pilot (McKinsey)	0	200
The Kensington – costs indemnified to Charity	0	320
Specialist paediatrics bid	28	197
Surplus / (deficit) against plan before release of provisions and exceptional items	**10**	**(1,407)**

2.4 Income was significantly ahead of plan for February by £4.43m, due to high levels of activity and the collapse of provisions; expenditure was £3.47m above plan, largely in response to activity. resulting in an increased EBITDA against plan of £0.96m.

2.5 Net surplus is £0.47m above plan in March, reflecting deficit against interest receivable (£0.103m), depreciation (£0.299m) and loss on disposal of fixed assets (£0.12m), offset by a surplus on interest payable (£0.02m).

2.6 £5.44m (80%) of the £6.76m annual savings requirement has been delivered. This is in line with the forecast at Month 11.

2.7 The Trust cash position in the month is £32.05m which is ahead of the Monitor plan by £15.28m. (See section 11 for details)

2.8 The Key Performance Indicators (KPIs) for working capital that were agreed as part of the Monitoring Plan are shown in the table below against the year to date and forecast KPIs.

	Mar 08	Feb 09	Mar 09	
KPIs	Opening Balance	Prior Month Actual	Current Month Actual	Monitor Plan
Stock days	34	37	41	33
NHS Trade Debtor days	8	5	8	7
Non-NHS Trade Debtor days	11	13	14	12
Trade Creditor days (Trust calculation)	29	17	15	13
Liquid Ratio (days)	65	61	49	34
Return on Assets Employed	5.2%	6.4%	6.2%	5.6%

2.9 The Capital Budget for the year has reduced from last month's reported position of £23.28m to £18.03m as a result of additional carry forward of £5.26m for projects not complete at year end.

2.10 The year to date actual spend for Capital Programme is £19.50m and represents a 7.0% overspend of the budgeted amount for the Capital Programme for the year.

Lorraine Bewes
Director of Finance and Information
May 2009

Members' Council Meeting, 18 June 2009

AGENDA ITEM NO.	3.2/Jun/09
PAPER	Annual Plan 2009-10
AUTHOR	Fleur Hansen, Business Planning & Strategic Adviser
LEAD	Lorraine Bewes, Executive Director of Finance
EXECUTIVE SUMMARY	This document was submitted to Monitor on 29th May 2009. The plan details the Trust's objectives in 2009-10 and going forward in the three-year planning cycle.
DECISION/ ACTION	The Members' Council is asked to note the paper.

Annual Plan
2009/10

Choose Chelsea and Westminster

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

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1. PAST YEAR'S PERFORMANCE

1.1 Chief Executive's Summary of the Year

2008/09 has been a challenging year for staff but I am pleased that we have been able to deliver on our key national targets, in particular on the challenging target of treating patients within 18 weeks of GP referral. The Trust was able to achieve this through the creation of additional capacity, ensuring timely discharges and vigilant management of waiting lists to maximise efficiency of both outpatient and inpatient appointments. Regarding waiting times in A&E, the Trust also continued its very strong performance during a difficult year for London trusts.

In terms of the infection control targets, I am pleased to report that we significantly outperformed both our external targets and the local targets agreed with our host commissioner, NHS Kensington and Chelsea, for both MRSA bacteremia and *C. difficile*. For hospital acquired MRSA the Trust recorded just five cases against the target of 19 cases set by the Healthcare Commission (now part of CQC, the Care Quality Commission) and the level three local target of nine cases. This is more than 50% less than the national average. The Trust also significantly reduced its *C. difficile* rates in 2008/09 recording 41 cases against the CQC target of 114 cases and the local target of 89. These low rates of infection were the result of excellent infection control procedures and strong leadership on wards to maintain high standards of cleanliness.

However, our satisfaction gained from meeting these targets was tempered by being reduced from Excellent to Good for Quality of Services for the annual Healthcare Commission (HCC) assessment for 2007/08, published in October 2008. We believe that this was due to not fully meeting one target related to the national Choose and Book system for which the Trust delayed the roll out following our discovery of a technical error whilst piloting the system earlier in the year. We believe it was correct to put the best interests of patients above the requirements of booking targets, even though the Trust 'failed' to keep up with the required targets for the number of services booked directly by GPs – 85-90% of services at Chelsea and Westminster are now directly bookable via Choose and Book. This rating was compounded by the HCC's late decision not to assess trusts on delayed transfers of care, lowering our overall rating. Given improved performance during 2008/09, the Trust expects to regain an Excellent rating for this past year.

The Trust delivered on its financial plan in 2008/09 through an increasingly challenging environment recording a surplus of £9.6m against a planned surplus of £7.9m. This surplus will be spent on service developments to improve patient care. This additional surplus was due to increased activity although this higher level of demand did not have the expected impact on EBITDA due to the additional costs involved. This demand meant the Trust had to take on locum and agency staff to treat patients within the 18 week deadline which therefore impacted on the expected conversion ratio. The Trust has plans in place to ensure that a more rigorous process is followed in 2009/10 to deliver services in a more cost effective way.

The Members' Council continued to play a valuable role in the development of the Trust. Membership for staff was converted to an 'opt-out' system after consultation with the Members' Council and with staff thus providing an additional 2,476 members. The Members' Council has been actively involved in the Trust's key projects in 2008/09 and played a vital role in rallying support for the location of a hyper-acute stroke unit at Chelsea and Westminster and recently coordinated an excellent open day on May 9. There is also a programme of continued development in place with a joint away day with the Board of Directors being held in December 2008.

Healthcare for London (HfL) and North West London PCTs have been active in designating specialist services over the past year with the Trust submitting bids for three services.

Stroke services were tendered for in November 2008 by HfL with the Trust applying to become a stroke centre thereby bidding for a hyper-acute stroke unit (HASU), a stroke unit (SU) and transient ischaemic attack (TIA) services. The preferred option put forward by HfL for public consultation

located a HASU at Charing Cross Hospital and not at Chelsea and Westminster, although this HASU may end up being located at St Mary's Hospital if it were to be designated as a major trauma centre. Given the Trust's excellent record for stroke care (we were ranked 3rd nationally for stroke services in the 2008 Sentinel audit), and our location being more appropriate to West London than St Mary's (which is only one mile from another HASU at UCLH), the Trust launched a public campaign to back our bid to become a HASU. HfL will review the responses and the final configuration is expected to be confirmed at the end of June.

2008/09 also saw the long awaited designation process for neonatal and specialist paediatric surgery and associated intensive care for North West London PCTs. The tender was received in late March with submission in early April 2009 and proved to be an example of excellent multi-professional working with both management and clinical staff dedicating time to ensuring we submitted the best possible bid. We were all therefore delighted to receive confirmation in mid-May that our bid had been successful and that Chelsea and Westminster from April 2010 will provide all neonatal and specialist paediatric surgery for NW London. The Trust has proposed a federated network model which will work with not only other tertiary centres in London (namely Great Ormond Street, Guy's and St Thomas's and the Royal Brompton) for the care of those children requiring a high level of intensive care, but also with district general hospitals throughout NW London, to ensure where possible, care can be delivered in a local setting. The Trust also expanded its Neonatal Intensive Care Unit (NICU) in 2008/09 to 43 cots, all of which can be ventilated if required.

The Trust already performs the majority of this surgery but in order to provide the best possible environment for patients and their families, an application for planning permission has been submitted to build a £28m 2-storey extension between the main hospital site and the St Stephen's Centre. The Netherton Grove extension will house the new paediatric centre with four new paediatric theatres, an extended High Dependency Unit and 18 day surgery bays, all in a child-friendly environment with appropriate facilities for families.

Hammersmith and Fulham PCT also tendered for community musculoskeletal (MSK) services with the Trust bidding for all three parts of the service – community MSK therapy, community MSK pain management and MSK clinical assessment and treatment services. The Trust already offers all three of these services in Kensington and Chelsea with our pain service receiving a high number of referrals from across NW London. The decision on this tender is expected mid-June.

The Trust's new state-of-the-art HIV and sexual health centre, 56 Dean Street, opened its doors in early March right in the heart of Soho. The centre provides appointment and walk-in testing services for patients in a modern environment utilising the latest technology and is one of only two NHS sexual health clinics in London to offer Saturday clinics.

The annual patient survey results for 2008 saw our overall performance improving with 94% of respondents rating their care as Excellent, Very Good or Good. Of the 80 questions used in both 2008 and 2007, the Trust was significantly better on 14 questions, significantly worse on one question and remained roughly the same on 65 questions. Areas where there has been a marked improvement include reduced waiting times for patients requiring admission from A&E, improved hand hygiene among medical staff, and more patient choice for planned admissions. The one question that the Trust performed significantly worse on was patients who had been bothered by noise at night from other patients. As improving the patient experience is a key objective for the Trust, we will focus considerable attention on this in 2009/10 and will introduce a real time patient feedback system as well as patient panels which will feed into the Patient Experience Improvement Group.

Regarding the annual staff survey for 2008, 61% of staff responded compared to only 53% in 2007 which puts the Trust in the top 20% of acute NHS trusts in England in terms of response rates. We were also ranked in the top 20% for a number of areas including good communication between senior management and staff, staff recommending the Trust as an employer, and staff reporting good opportunities to develop their potential at work. The Trust was also ranked in the top 20% for

staff feeling able to contribute towards decisions at work that affect them and the services they provide—this was an area of concern in the 2007 survey which has improved significantly in the past 12 months. However there was a deterioration in some areas related to annual appraisals and personal development plans – action plans have been put in place to address this.

In line with the priorities identified by Lord Darzi's report High Quality Care for All and its focus on improving quality and the patient experience, the Trust was selected as a pilot site for a joint Monitor and McKinsey project looking at not only understanding our patients but also how best to act to improve their experience. The project was rolled out to maternity with other services to follow in 2009/10.

The Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for NW London secured in 2007/08 and located at the Chelsea and Westminster, has formed the cornerstone of the Trust's research programme in 2008/09. The Trust is participating in round 1 projects including chronic obstructive pulmonary disease (COPD) discharge planning and medicines management along with implementing our own internal research strategy. In July last year the Trust held its inaugural Research and Development Open Day which was well attended by patients and the public with the aim of informing them how they could become involved with research – the main theme of the NW London CLAHRC.

Overall, 2008/09 has been a demanding year but one that has provided significant opportunities for the Trust in the future. I would like to take this opportunity to thank all staff for their commitment and effort throughout the year and look forward to a challenging but exciting 2009/10.

1.2 Performance against Corporate Objectives 2008/09

1. Focus on patient safety and quality

- The Trust delivered significant reductions in the main healthcare associated infections, *C. difficile* and MRSA in 2008/09 through maintaining consistently high levels of infection control. For MRSA the Trust had to achieve no more than 19 cases of hospital acquired MRSA bacteremia – by year end the Trust had in fact only recorded 5 cases. This was also a significantly better performance than the highest level (level 3) of the locally agreed stretch target (9 cases) with our host commissioner NHS Kensington and Chelsea. Regarding *C. difficile*, the Trust also significantly reduced the number of hospital acquired infections in 2008/09. The Trust recorded 41 cases outperforming the externally set threshold level of 114 by 64%. The Trust also had over 50% less cases than level 3 of the locally agreed stretch target of 89.
- The Trust maintained its NHS Litigation Authority risk management standard level 2 rating following on site assessment in December 2008. The Trust scored 48 out of 50 and this was made possible by putting systems in place to monitor compliance and in some cases establishing new ways of working.
- In 2008/09 the Trust started introducing clinical quality benchmarks commencing with month-on-month monitoring of Sentinel audit data for stroke care which resulted in improved outcomes.
- Services and directorates have identified clinical quality indicators for which a measurement system and local targets to deliver the related objective for 2009/10.

2. Deliver effective and efficient pathways of care

- The Trust delivered the 18 week target in full by December 2008.
- The Trust continued to maintain strong partnership working with PCTs in 2008/09 and in particular with our host commissioner, NHS Kensington and Chelsea. We have worked with our commissioners to deliver recommendations from *Healthcare for London: A Framework for Action* throughout the year with a focus on the services identified by HfL, namely paediatrics, stroke care and maternity services.
- The Trust achieved a higher level of surplus than anticipated in 2008/09 of £9.6m as opposed to £7.9m which was predicted for year end. This was driven by increased demand for services above plan and a one-off opportunity to release provisions.

3. Be the provider and employer of choice

- In the Annual Patient Survey for 2008, 94% of those surveyed rated their care at the Trust as Good, Very Good or Excellent. This was an improvement of 4% on the final results for 2007.
- The tender for a patient experience tracker system was awarded in March 2009. In addition we will also be forming patient panels which will feed into the Patient Experience Improvement Group who will be responsible for the delivery of improved patient experience.
- The Trust was selected as the pilot site for a patient experience project developed by Monitor and McKinsey. The project aimed at embedding a consumer-centric culture through service line management was successfully undertaken in maternity services and will be rolled out to other services throughout 2009/10.
- 61% of staff completed the Annual Staff Survey for 2008, compared to only 53% in 2007. Of the 26 key findings, the Trust improved or broadly remained the same for 85%.
- The Trust was a leader for London in complying with the European Working Time Directive (EWTD) and at the end of 2008/09, was 95% compliant with maximum 48 hour weeks for all doctors in training.
- In 2008/09 the Trust saw an increase in activity in all specialities mainly due to an unforeseen increase in demand. We were able to ensure that patients were treated within in the 18 week pathway. The patient base will also be increased going forward through the securing of tenders such as stroke services.

4. Deliver excellence in teaching and research

- An internal system was introduced for gaining feedback from all medical students who spend time with the Trust. Results collated in early 2009 indicated that circa 70% of students rated their experience at the Trust as Excellent.
- Following a selection process, King's College London and South Bank University were chosen to work in partnership with the Trust to provide clinical placements for undergraduate nursing.
- The Trust has been actively involved with the implementation of the CLAHRC (based at Chelsea and Westminster) in 2008/09 through active participation in the five round 1 research projects: COPD discharge, pneumonia admission, medicines management in acute care, case management in the community and HIV/Hep C testing in A&E and primary care.
- The Research Strategy Board was also formed to ensure the delivery of the research strategy.

5. Create robust infrastructure for the future

- The Trust undertook infrastructure mapping in 2008/09 in order to facilitate devolution with the result being increased investment in service line reporting information and a review of corporate structure.
- The governance arrangements of the Trust have been revised including a revised governance structure. Part of this was the creation of one Assurance Committee which provides a more rigorous and streamlined system for assurance in conjunction with the Audit Committee.
- The Trust successfully brought in house the ownership of the LastWord electronic patient record system and by recruiting the support team, will be able to maintain the system until such time as a national programme is decided on.

1.3 Summary of Financial Performance

The Trust has delivered all of the elements of the Financial Risk Rating to plan in 2008/09.

This is summarised in the following table:

Table 1.1: Summary of Key Financial Highlights

	Actual 2007/08	Plan 2008/09	Actual 2008/09	Plan 2009/10
Financial Risk Rating	5	5	5	4
Income £m	258.2	267.1	280.7	307.8
EBITDA £m	30.4	24.2	26.6	26.5
EBITDA Margin %	11.8%	9.1%	9.5%	8.6%
Return on Assets £m	23.9	16.7	18.4	16.1
Return on Assets %	8.3%	5.5%	6.1%	5.5%
Net Surplus £m	14.6	8	9.7	6.4
Net Surplus Margin %	5.7%	3.0%	3.5%	2.1%
CIP achieved £m	8.9	6.4	5.4	9.1
CIP %	3.4%	2.4%	1.9%	3.2%
Liquidity Ratio days	59	61	49	24.7
Capital Expenditure £m	10.3	37.2	19	35.5
Depreciation £m	7.6	8.7	8.7	10.3
Net Current Assets/(Liabilities) £m	24.2	2.2	15.1	8.8
Stock Days	34	33	33	32
Debtor Days	8	7	7	8
Creditor Days	13	13	15	16

Income and Expenditure

The Trust's annual income and expenditure performance is set out in Table 1.2 below:

Table 1.2: Summary 2008/09 Income and Expenditure Outturn vs Plan (£m)

	Actual 2007/08	Plan 2008/09	Actual 2008/09	Variance 2008/09
Income				
Clinical Income	211.2	223.6	233.2	9.6
Non-Clinical Income	47	43.5	47.5	4
Total Income	**258.2**	**267.1**	**280.7**	**13.6**
Expenses				
Pay Costs	-134	-141.2	-148.1	-6.9
Non-Pay costs	-93.8	-101.7	-106.1	-4.4
Total Expenses	**-227.8**	**-242.9**	**-254.2**	**-11.3**
EBITDA	**30.4**	**24.2**	**26.6**	**2.4**

Depreciation	-7.6	-8.7	-8.7	0
Dividend on PDC	-9.3	-8.7	-8.7	0
Interest	1.1	1.2	0.6	-0.6
Subtotal	**14.6**	**8**	**9.7**	**1.7**
Exceptionals	0	0	0	0
Net surplus/(deficit)	**14.6**	**8**	**9.7**	**1.7**
CIPs	**8.9**	**6.4**	**5.4**	**-1.0**

The key variances are explained as follows:

- NHS clinical income was significantly above plan reflecting unplanned increases in referrals across most specialties not included in contracts with PCTs.
- Other income was higher than planned relating to retaining private maternity services under the Trust's management, increased income for facilities charges to recover higher energy costs and additional income for research and development and education and training.
- Pay costs were higher than plan because of increased activity with an increased proportion of agency staff as increases in activity were not anticipated in plans and initially not considered to be sustainable.
- Non-pay costs were higher than plan reflecting the costs of additional activity and increased energy costs.
- Falling interest rates associated with the economic downturn resulted in a shortfall against planned interest receivable.
- 80% of the cost improvement programme was delivered. The shortfall was offset by the non-recurrent release of balance sheet provisions no longer required.

Cash Flow

The cash balance at the end of the year was £15.28m ahead of plan. The reasons for this variance include:

- The planned loan draw down of £6.8m deferred until conclusion of the specialist paediatrics bid.
- Working capital improvement of £7.7m during 2008/09.
- Capital expenditure of £15.3m unspent in 2008/09 as planned as a result of capital slippages.
- A net interest receivable of £0.9m below plan as a result of the credit squeeze and recession in 2008/09.

Capital

The capital plan of £37.2m underachieved by 48% or £17.7m representing significant capital slippage during the year 2008/09, mostly relating to large building schemes (including the specialist paediatrics development and the single bed ward provision).

Approximately 80% of the under spend has been approved to carry forward to 2009/10 and the remainder subject to a further review process.

1.4 Other Major Issues

A significant change for the Trust in 2008/09 was the decision taken by the Members' Council following consultation with the staff constituency, to move to an opt-out system for staff members. This meant that all staff (including those on the staff bank) would automatically become members of the Foundation Trust upon employment with the Trust. The result was an overall increase in membership of 2,476.

Another significant development was the Board of Directors approval of the outline business case for the Netherton Grove development which will house the expanded paediatric theatres and

extended HDU. This was originally approved at £35m which would have been a material transaction. In the light of the economic downturn, the Board revisited the scheme and revised down the programme by £7.4m and is now confident that it is less than 10% of gross assets and income and therefore is not a material transaction.

The funding for this has been allocated and has been accounted for in the above financial performance. This extension will not only aid the delivery of neonatal and specialist paediatric surgery in North West London for which the Trust is the centre, but it will also extend our day case surgery beds in a state-of-the-art facility. The Board of Directors will provide a self-certification to Monitor that this material transaction will not impact on its planned risk rating before financial close as required by the *Compliance Framework*.

At the beginning of 2008/09, Ms Amanda Pritchard, Deputy Chief Executive and Director of Integrated Service Delivery and Modernisation was on maternity leave during which time Mrs Mariella Dexter was appointed as interim Director of Integrated Service Delivery and Modernisation and as such was a member of the Board of Directors. Ms Pritchard returned from maternity leave in early July 2008.

2. FUTURE BUSINESS PLANS

2.1 Overall Vision

2.1.1 Vision Statement

The Trust's vision was captured in the application for Foundation Trust status in May 2006:

> *"To deliver safe care of the highest quality for our local population and those using our specialist services, provided in a modern way by multi-disciplinary teams working in an excellent environment, supported by state of the art technology and world class academic research."*

2.1.2 Formation of Vision

The vision statement was formed during the process of preparing for foundation trust status through consultation with the Board of Directors.

The Trust was keen to have a smooth transition from NHS trust to foundation trust, which has been achieved over the past three years as evidenced by our consistent successful delivery of national priorities, Trust financial plans and high quality clinical services. However, three years after being authorised as a foundation trust (FT), the Trust faces a different strategic context than at the time of making its FT application, as set out in the strategic overview below. As such, the Board of Directors will be refreshing the Trust's current vision and strategy during 2009/10, and expects to engage with the Members' Council and a wide group of stakeholders during this process.

2.1.3 Our View on the Future

The Trust recognises that it is moving into challenging times for the NHS and the wider economy and that the downturn will impact on our ability to deliver high quality services combined with the implications of *High Quality Care for All*. This is likely to have a further impact on our planned developments. We have already factored in a real terms cut of 1.6% in the base case and modelled furthermore aggressive reductions in the downside sensitivity test. This will require significantly greater efficiency and productivity to deliver at a time when also services are being transferred from hospitals out to the community.

Our vision, as stated above, is to be a provider of specialist services. The Trust already has an excellent reputation in burns care and HIV inpatients and recently has secured designation as the centre for neonatal and specialist paediatric surgery in NW London and also been designated as a stroke unit. However the Trust is determined to build on this strong foundation and will not only develop services which have synergies with those that are already established, but to also develop its services which function collaboratively with the community such as diabetes, dermatology and musculoskeletal therapy.

Within the 3-year planning cycle there will undoubtedly be changes in the provider landscape which will only be heightened by the financial climate. Chelsea and Westminster, as the only foundation trust in the sector, is well positioned to consider an acquisition or alternatively, offer more vertically integrated services by setting up more community clinics, as was done in 2008/09 with the Dean Street clinic for sexual health.

94% of our patients rate their care as Excellent, Very Good or Good but we recognise that one of our greatest weaknesses has been our administrative processes. In the next year we intend to improve our processes by not only procuring new technology but also by improving the productivity of administrative staff to enable a more streamlined and efficient system. Ensuring all staff add value will be a priority for the Trust in the future as will meeting the quality agenda which will be significantly enhanced by projects such as our real time patient feedback system and patient panels.

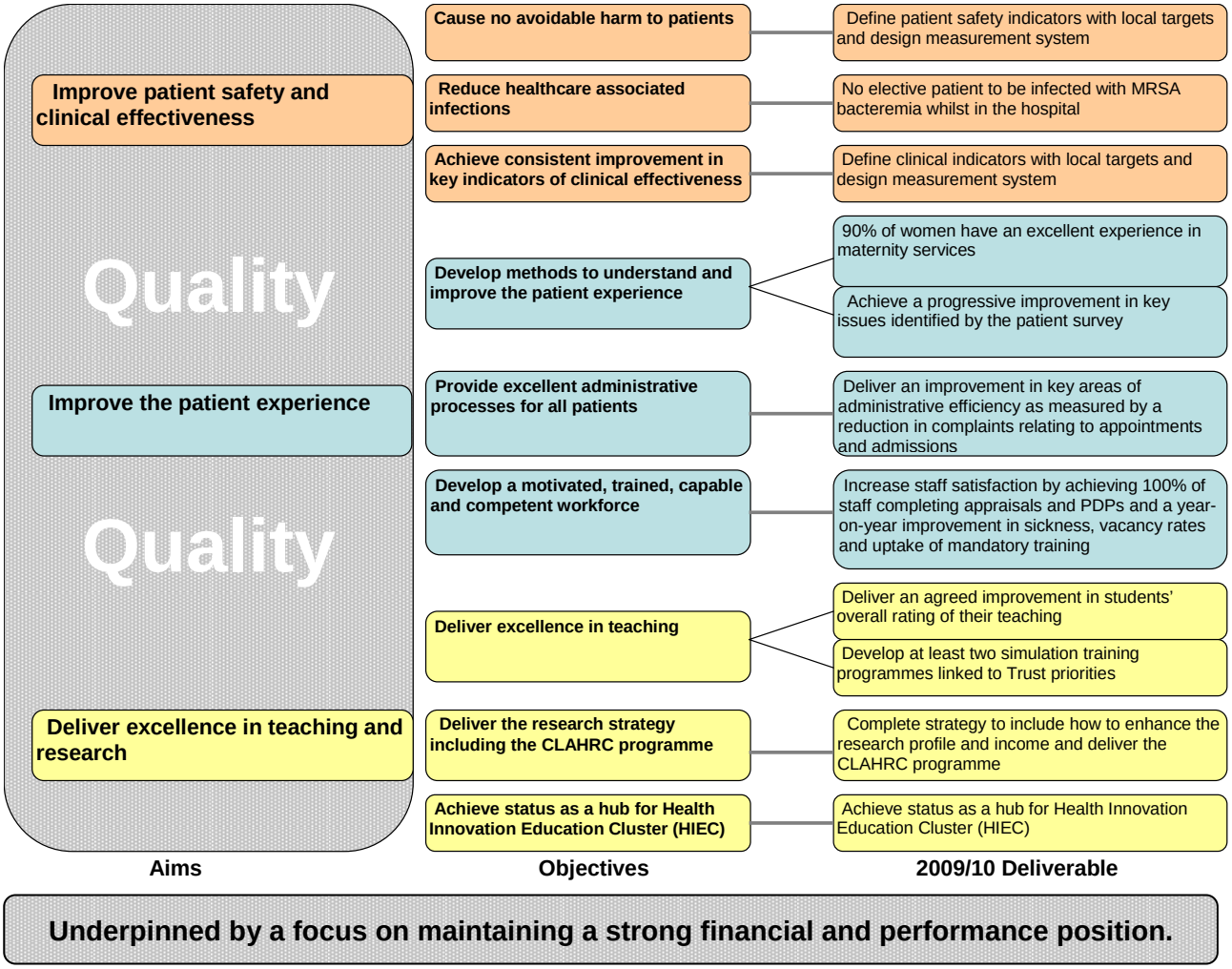
There is no doubt that the coming years will by tough for all NHS organisations, but the Trust is confident that it can build on its reputation and continue to deliver not only high quality specialist services but also to work in partnership with the community to ensure an excellent experience for patients.

2.1.4 Corporate Aims and Objectives

The Trust's vision has been encapsulated in the formation of the corporate aims and objectives for 2009/10. It is expected that the aims and objectives will remain broadly the same for the 3-year planning cycle but that the deliverables will be revised for each year.

The aims and objectives were selected through consultation with the Board of Directors, the Members' Council and input from staff. These objectives balance the interests of patients, the local community and other stakeholders and will form the basis of future planning and decision making.

Values and conduct of the Chelsea and Westminster Hospital NHS Foundation Trust and its staff are in accordance with NHS values and accepted standards of behaviour in public life, which include the principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership (The Nolan Principles).



2.2 Strategic Overview

There are a number of external drivers which will impact on the Trust in 2009/10 and given their emergent nature will continue to do so in forthcoming years.

2.2.1 National Strategic Drivers

A key national strategic driver last year was delivering shorter waiting times to patients and meeting the national 18 week referral to treatment waiting time target. The Trust was pleased to deliver that key national target, but the focus for 2009/10 will be on ensuring sustainability of shorter waiting times. In particular, increased emphasis will be placed on redesigning elective pathways to deliver streamlined care and on ensuring that the referral process for patients is as smooth as possible.

The publication of Lord Ara Darzi's review of the NHS, *High Quality Care for All*, has brought a focus on quality to the forefront of discussions within the NHS, as defined by Lord Darzi as improving patient safety, patient experience and clinical effectiveness. Our Trust welcomes this focus on high quality provision, as evidenced by our commitment to corporate objectives that mirror the focus on safety, experience and clinical effectiveness. Our specific initiatives to drive up quality are detailed in a separate section below.

The Trust has started planning now for a slowdown in public sector spending as a result of the current economic environment. Our early focus on service line reporting, which the Trust piloted in partnership with the foundation trust regulator Monitor, gave us useful insights into the economics of our different services. We are committed to building on our early start by making service line reporting information easily accessible and open to analysis by a wide group of managers and clinicians as we plan for significant efficiencies in future years. We have also begun to launch projects that will look to deliver step-changes in productivity in our support services, beginning with an ambitious theatre productivity improvement programme.

European Working Time Directive (EWTD)

Achieving compliance with the EWTD will be a key driver for 2009/10 with trusts expected to fully comply with a maximum 48-hour week for doctors in training by August 2009. Chelsea and Westminster is one of the best performing acute trusts in London with 95% of rotas compliant with the 48-hour week and only three specialties still outstanding. These rotas will be resolved within in the next two months and the Trust is confident that it will be 100% compliant by 1 August 2009.

HRGv4 and Market Forces Factor

The introduction of HRG version 4 and rebasing of market forces factor (reduced from 40.2% to 33%) has resulted in a loss of £2.5m to the Trust for 2009/10 for the same level of activity that was delivered in 2008/09.

This loss includes the impact of scaling back outpatient diagnostic tariffs to 2008/09 adjusted values and reducing income relating to maternity events not resulting in a delivery (N12) which together resulted in a 'hit' of £4.9m. This was partially offset by non recurring transitional support from our major PCTs of £3.8m.

Implementation of HRGv4 has created significant shifts in tariffs most notably the maternity related tariffs which are substantially higher (but Clinical Negligence Scheme for Trusts contributions have increased significantly). Going forward we expect the loss to increase as market forces factor and specialist top ups reduce.

The Trust is working to ensure that we are able to ensure maximisation of income in the future years as the scope of HRGv4 is expanded.

Multi-professional Education and Training (MPET)

The Trust's plan takes account of the national review of funding MPET activities. Under the proposed introduction of a tariff for MPET it is assumed there will be an income shift away from traditional teaching centres such as our Trust.

2.2.2 Regional Strategic Drivers

A key strategic driver for London will be the ongoing implementation of the Lord Darzi report, *Healthcare for London: A Framework for Action* and the momentum behind it which will continue to have a significant impact on the delivery of healthcare in London. There are currently nine projects underway within the Trust with a number anticipated to impact on the Trust in 2009/10 and throughout the planning cycle. The projects likely to have the most direct impact on the Trust are listed below:

Stroke Care
Designation for stroke services commenced in October 2008 with the Trust bidding to become a stroke centre for London incorporating a hyper-acute stroke unit (HASU), a stroke unit (SU) and transient ischaemic attack (TIA) services. The public consultation ended early May 2009 with the final configuration expected at the end of June.

Major Trauma
HfL is also reviewing major trauma services in London at the centre of which will be specialist major trauma centres (MTC), one of which will provide major trauma cover for NW London. Although the Trust has not bid to become a MTC, it would function as a trauma centre as part of the network and work with the designated MTC. The results of the public consultation are expected at the same time as stroke services at the end of June.

Children and Young People
Another of HfL's projects which will be active during 2009/10 will focus on the provision of care for children and young people incorporating primary and community, acute general and tertiary care. At this early stage of the project the Trust is participating through having representation on the clinical expert panel and providing input and data as requested. Key work streams that will impact on the Trust will be related to improving services and their delivery and the creation of networks. The Trust believes that its excellent reputation for providing paediatric services in NW London and the recent design and proposal of a network for specialist paediatric surgery in NW London will prove to be invaluable for the development of paediatric and adolescent services in London.

Urgent Care
HfL is also expected to designate urgent care centres in 2009/10. NHS Kensington and Chelsea indicated that they will tender for a service to be housed in the Chelsea and Westminster's accident and emergency (A&E) department. To this end, the Trust has been assisting K&C with information which will contribute to the formulation of the service specification and the anticipated impact on regional trusts of reduced A&E attendances due to the patients been seen in the urgent care centres. The Trust intends to bid to become an urgent care centre once the tender is published.

Maternity
Another key project for HfL in 2009/10 will be centred around improving maternity services. The HfL project will focus on managed networks of care and the possible creation of obstetric units given the potential changes in paediatric services. The Trust focused considerable resources on maternity services during 2008/09 as part of the Maternity Services Improvement Review and the Monitor/McKinsey Patient Experience Project and will continue to focus on improving maternity care in 2009/10. Given this, and the fact that the Trust will be the lead neonatal surgical centre for NW London, the Trust believes it will be in a strong position to feed into this project.

HIV Inpatient Care
Although not confirmed, there is likely to be some reconfiguration of HIV inpatient services in London during 2009/10. The Trust has a well established reputation in HIV care and would be in a strong position to be designated as an inpatient facility if this was the approach taken by the specialist commissioners.

Polyclinics
An early priority for HfL was to create polyclinics to provide routine hospital care and imaging in a community GP setting with so far one polyclinic being set up in our region at Hammersmith Hospital. Future polyclinics will be tendered for in 2009/10 and the Trust anticipates this will include one in the South Westminster area where we currently provide outreach services. The creation of polyclinics in North Kensington and North Wandsworth would also be expected to impact on the Trust through reduced A&E attendances and locally provided services such as imaging. As and when these polyclinics are tendered for, the Trust will ensure that it is informed with any effect on its services and how best to interface with them.

Academic Health Science Centres (AHSCs)
The creation of AHSCs, in particular the one more local to us, Imperial College Healthcare NHS Trust will potentially impact on the Trust's research and academic functions, as well as ensuring we continue to recruit strong medical staff. The key to ensuring these areas are not negatively impacted on, will be through building an interface with all the AHSCs in London. The Trust already has strong links with Imperial College Healthcare's AHSC through our role as an academic provider for Imperial College and will build links with other AHSCs in London. As part of the tender for neonatal and paediatric specialist surgery the Trust described a federated model for NW London which we believe will be useful in ensuring participation in the work of the AHSCs in London.

2.2.3 Local Strategic Drivers

Neonatal and Specialist Paediatric Surgery
NW London PCTs designated Chelsea and Westminster the lead centre for neonatal and specialist paediatric surgery in May 2009 following a bidding process in late March and early April. This will be a key local driver for the Trust throughout 2009/10 in order to meet the go live date of April 2010. More detail on this is provided in the initiatives section below.

Collaboration for Leadership in Applied Health Research Care (CLAHRC)
The CLAHRC for NW London is hosted by Chelsea and Westminster and as such the Trust will take a leading role in promoting research projects as well as other CLAHRC activities. The process for identifying round 1 research projects began in April 2009 with successful projects to be announced in December following proposal development and a peer review process. The five round 1 research projects are HIV community testing, medicines management, chronic obstructive pulmonary disease discharge care bundle, community acquired pneumonia care bundle and case management in the community, of which the Trust is involved in the first four.

Health Innovation Education Cluster (HIEC)
Although this is a national driver, the implementation will be on a local basis in NW London. The Trust intends to bid to become a HIEC in conjunction with NW London partners including Imperial College AHSC, NW London PCTs, NW London provider trusts, and other associated health and academic organisations in July 2009.

NW London PCT Alliance
Hammersmith and Fulham, Kensington and Chelsea and Westminster PCTs decided to work more closely to streamline working practices and improve efficiency and from 2009/10 acute commissioning will be handled by an alliance formed by all three PCTs rather than by our host commissioner, NHS Kensington and Chelsea. The Trust intends to build on its collaborative working with the individual PCTs to develop strong relationships with the new body.

Commissioning for Quality and Innovation (CQUIN)
CQUINs is a national driver, but the implementation will be on a local basis with our local commissioner, NHS Kensington and Chelsea. It will mean that a proportion of provider's income will be conditional on meeting locally determined quality and innovation goals. At this stage the

Trust is still finalising the CQUIN schemes for 2009/10 with the PCT but which will most likely be on initiatives related to infection control, discharge planning and medicines management.

Provider Landscape

The provider landscape will undoubtedly change in the forthcoming years with NWL PCTs believing that the number of provider trusts in the region will be streamlined. The commissioners have identified two fixed 'points' in the area – Chelsea and Westminster as a foundation trust and Imperial College Healthcare NHS Trust as an AHSC. The Trust will cooperate in discussions with NWL PCTs over any changes in the provider landscape.

Memorandum of Understanding with Royal Brompton and Harefield NHS Trust

In March 2009, a Memorandum of Understanding was signed between the Chelsea and Westminster and the Royal Brompton and Harefield NHS Trust (RBH) to explore opportunities for closer cooperation and collaboration between both trusts in the future. In the immediate term, RBH and Chelsea and Westminster have agreed to collaborate specifically over paediatric care and build on existing clinical partnerships to strengthen paediatric services for the benefit of patients at both trusts.

2.2.4 Quality

Our focus on quality improvement, which has been a key theme of the Trust's corporate objectives for a number of years, has ensured that we have set high standards for quality. The Trust is amongst the top 20% of NHS trusts in England with significantly lower than expected Hospital Standardised Mortality Ratios (HSMRs), we achieved NHS Litigation Authority risk management standards level 2 in December 2008, passing 48 out of 50 criteria in five areas of risk management and in 2008/09 significantly outperformed both national and local targets for the reduction of both MRSA and *C. difficile*. In the Annual Patient Survey results for 2008 94% of patients rated our services as Excellent, Very Good or Good.

We are committed to building on these solid foundations to improve quality further. The Board of Directors has agreed that the Trust's top three priorities for quality improvement in 2009/10 should be as follows:

Decrease in the Incidence of Preventable Venous Thromboembolism (VTE)

To reduce our preventable VTE rate by 15% in the next year. This is a priority as VTE is a major cause of preventable death and reducing its incidence is a national priority for the NHS. It is estimated that in England each year more than 25,000 people die from VTE contracted in hospital and one in three patients undergoing surgery in hospital can develop VTE if no preventative measures are taken. In addition, non-fatal VTE can require treatment with anticoagulant drugs at doses with a significant risk of bleeding, causes delays in patients' discharge home from hospital, and often results in readmissions to hospital.

The Trust has established a multi-disciplinary committee to facilitate this priority for quality improvement. The committee will oversee implementation of the recommendations of the Chief Medical Officer's expert working group on the prevention of VTE in hospitalised patients, implementation of National Institute for Health and Clinical Excellence (NICE) guidance, and adherence to Trust guidelines on VTE prevention including the use of an electronic risk assessment tool and audit of prescribing. Improvement will be measured by the rates of hospital acquired VTE with the aim of reducing preventable VTE by 15% in the first year.

Improvement in Patient Experience in Maternity Services

To increase the percentage of women who have an Excellent experience of our maternity services to 90% in the next year. This is a priority as high quality maternity services are vital to the success of the Trust's overall strategy to be recognised as a centre of excellence in women's and children's health. Most women have a positive experience of maternity services at Chelsea and Westminster, however, there are known areas for improvement as a result of feedback from incidents and

complaints and the Trust wants to ensure that all women have as positive an experience as possible of our maternity services.

The Trust's maternity services were chosen as a pilot site for a patient experience project developed by Monitor, the foundation trust regulator, and McKinsey in 2008/09 to understand our patients and act on their concerns – in 2009/10 we will look to fully implement the recommendations from this project and embed a culture of continuous patient feedback and improvement. Improvement will be measured by real time patient feedback monitoring tools, in particular the Dr Foster Patient Tracker.

Reducing Delays in Emergency Surgery

To reduce delays for selected emergency operations of more than 24 hours. This is a priority as senior surgeons in the Trust have expressed concerns that the drive to meet the national 18 week target from GP referral to treatment combined with an increase in the number of patients requiring surgery and full implementation of NCEPOD guidelines that restrict out of hours operating may be exacerbating problems of delays for some patients requiring emergency surgery. The Trust is responding directly to these concerns by making the reduction of delays to emergency operations a priority for quality improvement in 2009/10. This work will also complement existing initiatives to improve the effectiveness and efficiency of the use of operating theatres.

Each surgical speciality is reviewing arrangements for emergency operating. Initiatives include the appointment of a dedicated consultant emergency surgeon for general surgery, appointment of a trauma nurse to focus on improving the pathway for patients with fractured neck of femur and a review of the plastic surgery trauma service including the 'hand room' and dedicated hand trauma theatre. In addition, a review of the management of emergency operating theatres is planned with a focus on creating clear leadership and efficient management of the emergency theatre list. Improvement will be measured by looking at time to operation to establish a baseline for each selected surgery procedure and individual targets will be set with the aim of a progressive improvement.

2.2.5 Key Actions

We are well positioned to continue to deliver on our aspirations and vision for Chelsea and Westminster.

Initiatives

Provider of Specialist Services

The Trust vision is one of securing sufficient specialist services to allow it to remain an attractive organisation for staff interested in specialist work and in education and research that is linked into specialist services. Our initiatives to secure our specialist work are outlined below.

Our investments in these specialist services have only been made possible by our retention of surpluses and our careful financial management.

Specialist Paediatric Surgery

2008/09 also saw the long awaited designation process for neonatal and specialist paediatric surgery and associated intensive care for NW London PCTs. The tender was received in late March with submission in early April 2009 and proved to be an example of excellent multi-professional working with both management and clinical staff dedicating time to ensuring we submitted the best possible bid. We were all therefore delighted to receive confirmation in mid-May that our bid had been successful and that the Joint Primary Care Trusts for NW London have recommended that from April 2010 Chelsea and Westminster will provide all neonatal and specialist paediatric surgery for NW London and will lead a paediatric surgical network for the sector.

The Trust already performs the majority of this surgery but in order to provide the best possible environment for patients and their families, an application for planning permission has been submitted to build a two-storey extension between the main hospital site and the St Stephen's Centre. The Netherton Grove extension will house the new paediatric centre with four new paediatric theatres, an extended High Dependency Unit and 18 day surgery bays, all in a child-friendly environment with appropriate facilities for families. The Trust will be accessing a significant loan to help finance this development, but one that is within the Trust's Prudential Borrowing Limit. An initial estimate of £35m has been approved by the Board in an outline business case to support this development, but this amount has now been revised downwards by £7.4m to ensure it is the most cost-effective way of securing the Trust's strategic objective.

Another key development to deliver the best possible care for paediatric surgical patients will be seamless working with other partner hospitals. The Trust has proposed a federated network model which will work with not only other tertiary centres in London (namely Great Ormond Street and Guy's and St Thomas's) for the care of those children requiring a high level of intensive care, but also with district general hospitals throughout NW London, to ensure where possible, care can be delivered in a local setting. The Trust also expanded its Neonatal Intensive Care Unit (NICU) in 2008/09 to 43 cots, all of which can be ventilated if required.

Achieving lead paediatric surgical centre status for the Trust is an excellent development as it allows us to consolidate one of our key areas of specialist service delivery.

HIV Inpatients

The HIV and sexual health directorate's stated strategy is to "be the leading centre for HIV and sexual health in London providing state-of-the-art care". Our opening in March 2009 of a new state-of-the-art sexual health centre in Soho, 56 Dean Street, was a key initiative to help deliver this strategy.

In anticipation of a future designation/de-designation or self-assessment process for HIV inpatients, the Trust is also looking to improve our existing inpatient facilities. Although our dedicated HIV inpatient ward, Thomas Macaulay, already provides good facilities for treating patients with HIV, changes in clinical treatments are driving the type of patient seen. The Trust is seeing fewer HIV inpatients as treatment regimes are made more effective, yet at the same time those patients we do see are generally less well and require higher levels of care and different facilities such as a greater provision of single rooms and negative pressure rooms. As such, we will look to invest some of our retained surpluses in redesigning the HIV inpatient ward so that it continues to provide the highest quality environment for our patients.

Stroke Care

In response to the Healthcare for London initiative to designate hyper-acute stroke units (HASUs), stroke units (SUs) and transient ischaemic attack (TIAs) services, the Trust bid to offer all three services and HfL is consulting on the Trust offering a SU and TIA service but not a HASU.

The public consultation was run from late January until early May with HfL putting forward a recommendation that Chelsea and Westminster be designated for SU and TIA services but not to become a HASU. HfL's recommendation was that Charing Cross Hospital, part of Imperial College Healthcare NHS Trust (ICHT) is the location for the HASU in our local area which we supported. However, we do have an issue with the way the consultation has been undertaken as the consultation indicated that if St Mary's Hospital (also part of ICHT) were to be designated as a major trauma centre, then the HASU would likely be co-located with major trauma at St Mary's. We believe if this were to happen, then it would call into question the reasons why the HASU was recommended to be located at Charing Cross, namely because it is co-located with neurosurgery and its geographical location. Placing a HASU at St Mary's would result in two HASUs being within one mile of each other (the other being UCLH) and may result in longer travel times for west London patients.

We also believe that our Trust would provide an excellent hyper-acute service, building on the strength of our existing stroke service whose clinical excellence is reflected in the Sentinel Audit of stroke services. For the most recent survey in 2008, the Trust was named the third best provider of stroke services nationally outperforming both Charing Cross and St Mary's as the Trust has in previous years. The responses of the consultation will be reviewed by HfL with a final configuration of services and implementation plan expected late June.

Regardless of whether the Trust is successful in achieving HASU designation, expansion of stroke services will be required in 2009/10 in order to meet the go-live date for the SU and TIA service. The current SU of 12 beds will require redeveloping to expand capacity to circa 24 beds (20 if we were also designated as a HASU) with the appropriate therapy and equipment space and also we would undertake a review of TIA space requirements. If the Trust was successful in HASU designation, we would redevelop ward space to also provide a 20-bedded HASU. Once the final decision has been made by HfL the Trust will immediately put into action its implementation plan in order to ensure the units will delivered by the start date designated by HfL.

Education and Academic Research

As well as focusing on investing in and improving our specialist services, the Trust has also taken actions to respond to the various drivers around education and academic research. In particular, the Trust has continued to support the North West London Collaboration for Leadership in Applied Health Research and Care and is working with other organisations to develop a bid for a local Health Innovation and Education Cluster.

Collaboration for Leadership in Applied Health Research and Care (CLAHRC)

The North West London CLAHRC is an alliance of academic and healthcare organisations working to develop and promote a more efficient, accelerated and sustainable uptake of clinically innovative and cost-effective research interventions into patient care.

A first round of projects has now been launched via the CLAHRC, and a brief summary of these projects is listed below:

- Improving the medication management from acute care at discharge by optimising pharmacy input and the use of telephony.
- Improving discharge planning for patients following an exacerbation of chronic obstructive pulmonary disease (COPD).
- Improving the immediate hospital assessment and management of community acquired pneumonia in acute hospital settings across NW London (roll out phase).
- Introduction of 'opt-out' blood borne virus testing in the non genito-urinary setting (emergency and primary care setting).
- To enhance patient care and improve overall system efficiency in the case management of very high service users across all interfaces of care.

Chelsea and Westminster is the hub for the NW London CLAHRC, and will continue to support this important endeavour, which we believe has enormous potential to improve the quality of healthcare for patients in NW London. In coming years, the Trust will continue to invest resources in the CLAHRC, and encourage our clinical staff to be involved in current and future projects. This continued involvement will help to underpin the Trust's existing academic credentials.

Health Innovation Education Cluster (HIEC)

The NHS Next Stage Review – *'A High Quality Work Force'* set out the proposal to develop Health Innovation and Education Clusters (HIECs). HIECs will revise the pace of change in the quality of healthcare professional education and training through excellence in provision. They will enable the adoption, implementation and embedding of innovation and improvement in patient care through elective and responsive based evidence and research.

The Trust is looking to work with a partnership of other NHS trusts and PCTs in NW London, and with academic institutions, industry and voluntary organisations to develop a compelling bid to be

designated as a HIEC. This bid is likely to build on the CLAHRC, which is London's only such collaboration and which already brings together NW London providers and commissioners.

Achieving HIEC status will again help to strengthen the Trust's future role in education and research, working in partnership with a wide range of organisations.

Provider Landscape

As discussed in the section on strategic drivers above, NW London PCTs and providers are in discussion about the future configuration of acute organisations in our sector. As a foundation trust we are considered a 'fixed point' within this sector, and as such options are being explored in regards to our Trust potentially acquiring another provider organisation.

Our Trust strategy has included an explicit assumption that we are likely to need to grow the size of our organisation to continue to operate effectively in a more competitive environment, particularly one in which Academic Health Sciences Centres may begin to realise scale efficiencies between organisations.

However, the Board of Directors is clear that any potential acquisition would need to be explored carefully to ensure that it was likely to be of benefit for patient services, and that such a move would benefit all provider organisations rather than harm clinical services or financial stability at any hospital. As such, any potential acquisition would receive extensive due diligence from the outset.

Compliance with Private Patient Cap

The Trust will continue to comply with the Private Patient Cap. The expansion of the Trust's private maternity unit has increased the level of profit that the Trust is able to achieve through private work, and has led to a review of other private work undertaken in the Trust. Through a new 'Private Patient Strategy' that will be delivered in 2009/10, we expect to be able to optimise the benefits to the Trust from private income.

Relationships with Healthcare Stakeholders

The Trust will continue to work closely with our local PCTs including NHS Kensington and Chelsea which has been our host commissioner in recent years. However, we will also look to forge strong new links with the acute commissioning alliance which is being established in NW London, and led by the chief executive of NHS Westminster. The Trust has enjoyed good relations with our neighbouring PCTs which was reinforced by our response to the PCT's tender of specialist paediatric surgery, and we fully expect to continue to work effectively with the new alliance.

The Trust has undertaken a survey of local GPs to better understand the perspectives of our key customers. The survey results were broadly positive about the services the Trust offers, and many respondents highlighted improved communication between our Trust and GPs which was encouraging and a result of the Trust's investment in GP communications. Key areas for improvement were around the referral and appointments process and a hospital directory and actions are being launched to address these areas.

Board Development

Board Development is facilitated by a number of initiatives including an Away Day and monthly seminars providing information on a range of topics including information technology, risk management, data security, safeguarding children, the NW London provider landscape, and mergers and acquisitions.

Engagement with Council Members and Membership and Delivery of Local Accountability

The Trust facilitates activities and events including the annual members' meeting, the annual Open Day, quarterly general meetings of the Members' Council, focus groups, and the Seasonal Working Conference which allow the Members' Council to engage with the membership. The Board of Directors hosted a joint Away Day to engage the Members' Council. Council Members are also

invited to sit on committees and panels. The Members' Council have been allocated a budget for membership and related activities and this facilitates their involvement.

The Trust informs the membership on issues through print and electronic media including semi-annual members' editions of Trust News, a dedicated Information Zone with screens, kiosks and bench seating, the website www.chelwest.nhs.uk, educational events and direct contact.

2.2.6 Service Development Plans

The significant service developments are listed below

Specialist Paediatrics Surgery – See above.

Stroke Care – See above.

56 Dean Street
The Trust opened its new sexual health and HIV centre, 56 Dean Street in March 2009 with this expected to increase demand for outpatient attendances for HIV services and genito-urinary medicine. Services were transferred from the Victoria clinic in SW1 due to an insufficient capacity for the increasing demand for these services and it is expected that due to Dean Street's more appropriate location, its state-of-the-art and modern environment, and the availability of evening and Saturday appointments, there will be further demand for these services over the planning cycle. The opening of this centre was supported by our commissioners and HfL and fits with the needs of the local population who live and work in Soho. This also fits with our strategy to "be the leading centre for HIV and sexual health in London providing state-of-the-art care".

Neonatal Critical Care
In line with continuing demand for neonatal critical care and following the Trust's designation as the lead centre for neonatal surgery in NW London, this service will continue to be an area of volume growth in 2009/10. The level 3 neonatal unit has expanded its cot base to meet this increased demand from 32 to 43 cots, all of which can be ventilated if required to provide critical care. This expansion has been supported by NW London commissioners and will build on the Trust's strong reputation for neonatal services.

Urgent Care Centre
The Trust anticipates that with the creation of urgent care centres, significant volumes of minor and standard type attendances will be redirected from our A&E department. Although this designation process may not be completed in 2009/10, it will certainly impact on the three year planning cycle. NHS Kensington and Chelsea have indicated that they would be interested in locating an urgent care centre at the Trust and we would then bid for this service.

Burns Redevelopment
During 2009/10 the Trust will be redeveloping its burns service as part of the process of becoming one of two Burns Centres in London and the South East. £3.1m capital funding was allocated and received from the Department of Health via the London and South East of England Burns Network along with £485,000 recurring for workforce. The first stage of the redevelopment will begin in the second half of the year and will provide additional ITU beds as well as improved segregation of paediatric patients.

Table 2.0 Significant Service Developments over the next 3 years

	Impact year			Activity impact (cumulative)			Cumulative Financial Impact £000's*		
Development	**09/10**	**10/11**	**11/12**	**09/10**	**10/11**	**11/12**	**09/10**	**10/11**	**11/12**
Specialist Paediatrics		FYE	FYE		752	752		4,699	4,637

Dean Street	PYE	PYE	FYE	16,828	22,136	27,444	2,002	2,915	3,828
Stroke	PYE	FYE	FYE	255	510	510	406	812	812
Child Critical Care	PYE	FYE	FYE	2,041	2,569	2.569	2,540	2,676	2,676
Urgent Care Centre		PYE	FYE		(28,893)	(48,105)		(1,149)	(3.346)
Burns Redevelopment	PYE	FYE	FYE	54	54	54	786	1,229	1,229

The tables 2.1 (i)-(iii) detail the top 6 service developments that are incorporated into the 3-year business plan for the organisation:

Table 2.1 (i): 2009/10 Impact

	Activity included in 2009/10 contract	Financial & activity implications in Annual Plan 2009/10		Financial & activity implications excluded from Annual Plan 2009/10
		Capital	Revenue	
Soho Sexual Health Centre	16,828		2.002m	Part of the growth is in the signed contract but a significant element is not in the agreed plans but will be recovered in year as a variance
Specialist Paediatric Centre		10.7		FYE in 2010/11
Stroke Care	255		406k	PYE in 2009/10 and full year effect 2010/11
Urgent Care				PYE in 2010/11 and full year effect 2011/12
Child Critical care expansion	2,510		2.540m	Part of the growth is in the signed contract but a significant element is not in the agreed plans but will be recovered in year as a variance
Burns Redevelopment	54	3.1m	789k	PYE in 2009/10 – in year additional funding in contract 0.3m the balance in line with costs incurred. All the capital funding of 3.1m has been received

Table 2.1 (ii): 2010/11 Impact

	Forecast activity impact in year	Financial & activity implications in Annual Plan 2010/11		Financial & activity implications excluded from Annual Plan 2010/11
		Capital	Revenue	
Soho Sexual Health Centre	5,308		913k	Reflected in full in the 2010/11 Monitor plan
Specialist Paediatric Centre	752	15.1	4.699m	Reflected in full in the 2010/11 Monitor plan
Stroke Care	255		406k	Reflected in full in the 2010/11 Monitor plan
Urgent Care	(28,863)		(1,149)m	Reflected in full in the 2010/11 Monitor plan
Child Critical care expansion	528		614k	Reflected in full in the 2010/11 Monitor plan
Burns Redevelopment	0		440k	Reflected in full in the 2010/11 Monitor plan

Table 2.1(iii): 2011/12 Impact

	Forecast activity impact in year	Financial & activity implications in Annual Plan 2011/12		Financial & activity implications excluded from Annual Plan 2011/12
		Capital	Revenue	
Soho Sexual Health Centre	5,308		913k	Reflected in full in the 2010/11 Monitor plan
Specialist Paediatric Centre		2.7		No additional impact over impact in 2010/11
Stroke Care				No additional impact over impact in 2010/11
Urgent Care	(19,242)		(2,197)m	The expected loss of income is at a higher rate in 2011/12 because we will recover less income relating to enhanced major attendances
Child Critical care expansion				No additional impact over impact in 2010/11

2.3 Summary of Financial Forecasts

2.3.1 How the Plan was built

The Trust is improving its financial planning processes by moving towards a planning framework for its directorates which is consistent with the methodology used by Monitor to assess performance of the Trust.

The initial assessment of the 3-year plan was presented to the Finance and Investment Committee and Board of Directors for consideration in December 2008. The financial planning principles were agreed at this meeting together with an assessment of the cost improvement target for each directorate.

Directorates were required to prepare their plans to deliver activity and quality targets and quantify the financial impact of cost pressures, business cases, inflation and activity related costs.

These plans were subject to challenge through bi-lateral meetings between directorate managers and the executive team and were formally agreed at a meeting of the Board of Directors on 29 April 2009.

The traditional rollover budgeting process has been replaced by a requirement for directorates to actively plan their resources to deliver activity and quality targets and also assess the risk of delivering their financial plans and develop mitigation plans.

2.3.2 The Impact of International Financial Reporting Standards (IFRS)

There are no significant accounting adjustments following transition to IFRS. The audited IFRS restatement of the Trust's opening balance sheet on 1 April 2008 and ongoing review of 2008/09 accounts reveal a net impact on reserves of £1.3m which is considered immaterial in the context of total costs to which it relates to.

2.3.3 Key Financial Assumptions

The 3-year financial plan is based upon a number of principles:

- To ensure the Trust continues to deliver an excellent rating for use of resources and quality of services.

- To generate surpluses which allow for reinvestment in developing services most notably the paediatric specialist centre for NW London.
- To reflect the changing economic environment in which the Trust is operating and to plan for possible reductions in the level of income.
- To reflect new cost pressures which were not anticipated in previous plans.

Financial Risk Rating

The following table shows how the Trust is planning to deliver a financial risk rating over the 3-year period which maintains an excellent rating for use of resources.

Table 2.2: 3-Year Financial Risk Rating

	2009/10	2010/11	2011/12
EBITDA Margin	3	4	4
EBITDA % Achieved	5	5	5
Return on Assets	4	4	3
I&E Surplus Margin	4	5	4
Liquidity (days)	4	4	4
Risk Rating	**4**	**4**	**4**

EBITDA performance improves reflecting the specialist paediatrics development whilst a reduction in liquidity reflects reinvestment of cash generated from prior year surpluses into capital investment.

Summary Income and Expenditure Plan

The following table summarises the income and expenditure plan for the 3-year period.

Table 2.3: 3-Year Income and Expenditure

	Plan 2009/10	Plan 2010/11	Plan 2011/12
Income			
NHS Clinical Income	253.6	261.7	253.7
Other Clinical Income	10.2	10.2	10.2
Research & Development Income	4	3.4	4.3
Education & training Income	22.8	21.6	20.5
Other Income	17.3	17.5	17.9
Total Income	**307.9**	**314.3**	**306.6**
Expenses			
Pay Costs	-160	-163.9	-163.1
Drug Costs	-47	-47.3	-46.8
Clinical Supplies	-32.1	-31.4	-30.4
Other Non-Pay costs	-42.2	-39.1	-34.4
Total Expenses	**-281.3**	**-281.1**	**-274.7**
EBITDA	**26.6**	**33.2**	**31.9**
Depreciation	-10.3	-12.3	-14
Dividend on PDC	-9.2	-9.7	-10.2
Interest	-0.7	-1.4	-1.4
Subtotal	**6.4**	**9.9**	**6.2**
Exceptionals	0	0	0
Net surplus/(deficit)	**6.4**	**9.9**	**6.2**
CIPs	**9.1**	**9.8**	**10.9**
CIPs as a % of expenditure	**3.2%**	**3.5%**	**4.0%**
Activity			
Elective - Short stay activity	22,573	22,632	22,632

Elective - Long stay activity	5,035	5,169	5,169
Non-Elective	31,461	31,588	31,588
Outpatient	409,666	415,224	420,532
A&E	100,638	71,775	52,533
Other	286,149	287,119	287,119

The following assumptions have been applied.

NHS Clinical Income

Contract income negotiations with commissioners are complete and the Trust's income plan is now set for £308m compared with actual outturn for 2008/09 of £281m, an increase of 9.6%.

The key points to note in relation to NHS clinical income are as follows:

- Overall growth of 9.4%.
- The impact of the new Payment by Results tariff and reductions in the market forces factor for 2010/11 and 2011/12.
- Funding of £1.1m relating to Commissioning for Quality and Innovation (CQUIN) which is conditional on achieving quality indicators.

Other Income

MPET loss of £6.25m over 5 years commencing from 2010/11 to anticipate the introduction of an MPET tariff and withdrawal of transitional funding for SIFT, MADEL and NMET activities.

Transitional funding for research and development and continuation of the CLAHRC programme.

Private income is planned to increase from £7.9m to £9.3m which is 3.5% of clinical income and therefore at the threshold of 3.5%. This assumes £4.3m for private maternity and £5m for adult private patients.

Operating Expenditure

The Trust has completed its assessment of resources required to deliver the capacity to deliver quality and activity targets. Expenditure plans reflect a revenue cost of £11.3m for cost pressures, £4.1m for business cases and £13.4m to deliver activity increases.

A number of cost pressures have been identified through the planning process. These include:

- Increased energy costs (£1m).
- Reduced interest receivable reflecting the reduction in interest rates (£0.8m).
- Increased costs of the Clinical Negligence Scheme for Trusts (CNST) (£1.6m).

The Trust has set aside £2.1m of contingencies for unforeseen events (0.8% of turnover).

Inflation

The following assumptions have been made for inflation (detailed in Appendix 1):

- NHS clinical income inflation is assumed to reduce to 1.2% in 2010/11 with deflation of 1.6% in 2011/12. This reflects that a number of commentators now expect there to be a real terms cut in public spending from 2011/12, as the first year in the next 3-year settlement.
- Pay awards are assumed to equal non-pay inflation on the expiry of current pay award deals (March 2010 for medical staff, March 2011 for other staff).
- Non-pay inflation is based upon the latest Bank of England forecast.
- No provision has been made for drugs inflation savings until national procurement contracts are available for review. It is noted that the Department of Health expect a fall in drugs prices over the 3 year period although the Trust perceives these will be realised in the primary care as opposed to the acute health sector.

- A reduction of 2% in VAT until December 2009.
- A 0.5% increase in employers' national insurance from 2011/12.

A more detailed analysis of movements in income and expenditure is included within the bridging statements in Appendices 2 and 3.

2.3.4 Phasing

NHS activity and income is phased to deliver greater volumes of activity in the first six months of the year. This is to ensure the Trust is ahead of key access targets and does not need to incur premium cost at the end of the year associated with treating exceptional levels of activity above efficient capacity levels.

Expenditure is planned to match the activity profile with service developments planned to commence in line with latest planning assumptions.

The capital programme is phased to reflect the latest planning assumptions and a prudent estimate of potential slippage which is associated with a major programme.

The outcome of the phasing is that the Trust expects to deliver a greater surplus in the first months of the year reflecting fixed costs being profiled equally through the year and increasing capital charges through the second six months of the year.

2.3.5 Investment and Disposal Plans

The Trust plans to utilise the surpluses that have been generated over the last two years towards a significant increase in the capital programme over the planning period compared with previous years. This ambitious capital programme will have three main strands:

- To provide additional services that will allow the Trust to grow its core services.
- To provide essential renewal of equipment and information services.
- To maintain the existing estate at a high standard.

The most significant development for the Trust is the bid to establish a paediatric specialist centre for NW London. Other key service developments proposed are for adult burns services and single sex wards.

The Trust is proud of its unique hospital building which is now 16 years old. However, the building requires maintenance to keep it to the high specification it has enjoyed and to retain its visual impact which makes a valued contribution to the patient experience. The Trust is therefore planning a challenging programme of maintenance between £3m to £4m for each year of the planning cycle.

Table 2.3 below shows how this is split between maintenance and non-maintenance capital.

Table 2.4: Investment (including new contracts) and disposal plans

£ million	Plan 2008/09	Actual 2008/09	2009/10	Current Plan 2010/11	2011/12
Investment in PPE (non-maintenance)	30	13.2	28.4	26.6	9.3
Investment in PPE (maintenance)	4.3	5.8	7.1	5.6	4.5
Investment in other assets	0	0	0	0	0

Asset disposals					
Protected	0	0	0	0	0
Mixed use	0	0	0	0	0
Unprotected	0	0.1	0	0	0
Protected asset declassifications					
Protected to unprotected	0	0	0	0	0

A summary of the capital programme for the next three years is included in table 2.4 below (a detailed analysis is attached as Appendix 4). The Trust has no plans to dispose of any assets or to have any protected assets declassified.

Table 2.5: Capital expenditure plans

£ million	Plan 2008/09	Actual 2008/09	2009/10	Current Plan 2010/11	2011/12
Capacity Expansion	7.5	0	19.1	18.5	2.7
Condition Maintenance of Property, Plant and Equipment	4.8	3.4	7.1	5.6	4.5
IM&T Developments	0	0	5.1	2.9	2.1
Clinical Space Development	0	0	1.8	3.9	2.7
Other Clinical Developments	0	0	1.6	1.0	1.5
Other minor projects	24.9	15.7	0.8	0.3	0.3
Total	**37.2**	**19.1**	**35.5**	**32.2**	**13.8**
Financed from:					
Surpluses	40.0	19.1	22.5	18.2	13.8
Disposals	0	0			
Loans	6.7	0	13.0	14.0	0

2.3.6 Loans and Working Capital

Working Capital Facility

The Trust currently has a committed working capital facility of £20m which is set up in compliance with all appropriate regulations. This was equivalent to 30 days operating expenses in 2008/09.

The current committed facility is due to expire on 6 November 2009 and will be renewed to provide the Trust with a committed working capital facility of £20m for one year. The Trust will renew it each year to continue the facility at the level of £20m for 2010/11 and 2011/12. The new working capital facility is equivalent to 30 days operating expenditure in 2009/10. The facility was not used in 2008/09 and it is not anticipated that any of it will be utilised over the full three year planning cycle.

The Trust has liquidity headroom of £37.9m for 2009/10. The liquidity headroom calculation is derived from both cash at bank of £17.9m and the unused committed working capital facility of £20m at the end of 2009/10.

Loans

The Trust has an outstanding long term loan of £11m in place with the Foundation Trust Financing Facility at the start of 2009/10, on which the Trust will be making a repayment of £1.5m in 2009/10; interest payable on this loan is fixed at 4.85%. The Trust intends to take out a new loan for £27m, with the Foundation Trust Financing Facility to fund the Netherton Grove extension. The Trust will draw down the loan in four instalments between 2009/10 to 2010/11: £6m in December 2009, £7m in March 2010, £7m in July 2010 and the final £7m in November 2010. Repayment will begin in

March 2011. The new loans have not yet been secured therefore interest is calculated on the public works loan board rate for a 15-year equal instalment payment loan. While the Trust is proposing in this plan to take out an additional loan, the Board has reflected at length on the affordability of the capital programme in the light of the economic downturn and is continuing to work on further downside cases and may wish to resubmit its plan as part of the further downside modelling required by Monitor.

Prudential Borrowing Limit

The prudential borrowing limit set at £37.8m for 2008/09 is expected to change for 2009/10 to £57.1m. The Trust does not intend to maximise borrowing against this limit during 2009/10 and will be able to meet all ratios in the Prudential Borrowing Code in 2009/10.

2.3.7 Cost Improvement Plans (CIPs)

The Trust has recognised the changing economic environment in which it will need to operate in the medium term, and is planning for cost improvements of 3.2%, 3.5% and 4% of expenditure for the next three years.

To deliver sustainable savings requires an organisation wide approach to delivering efficiencies and needs to be supported by robust programme management arrangements.

Whilst delivering these savings represents a challenge for the Trust, a number of themes have been identified to support delivery of the cost improvement plan. These are summarised in the following table:

Table 2.6: 3-Year Cost Improvement Plan

	Current Plan (£m)		
	2009/10	2010/11	2011/12
Income Generation Schemes	3.7	1.0	0.5
Procurement	1.4	2.7	3.7
Agency Staff	0.4	0.6	0.0
Clinical Service Redesign (Including Technology Projects)	1.9	2.5	3.7
Back Office, Shared Services & Outsourcing	0.0	0.5	0.5
Medicine Management	0.3	0.5	0.5
Asset Utilisation, Energy Management & Managed Equipment Services	0.2	1.5	1.5
Other	1.2	0.5	0.5
Total CIPs	**9.1**	**9.8**	**10.9**
Recurrent	9.1	9.8	10.9
Non recurrent	0.0	0.0	0.0
% of cost base	3.2%	3.5%	4.0%

Key initiatives include:

- The Trust is planning to reduce agency costs through a combination of substantive appointments to deliver activity increases, introducing a specialist bank rate to incentivise staff to transfer from agencies, robust monitoring of agency costs supported by the introduction of a quota system and reducing the number of agencies it contracts with.
- Ensuring activity is coded correctly and the Trust maximises NHS clinical income through Payments by Results.
- Reviewing staffing levels and working practices to support clinical services.
- Developing a collaborative approach between procurement and directorates to deliver lower cost and best value purchasing.

3. RISK ANALYSIS

3.1 Governance Risk

The Chelsea and Westminster Hospital NHS Foundation Trust anticipates that it will retain its **green** governance risk rating for 2009/10 based on the evidence set out below:

3.1.1 Governance Commentary

Growing a Representative Membership
The Trust continues to be committed to growing a representative membership. The Trust commissioned work profiling segments of its public membership and has identified geographic, age and socio-economic segments of both over and under-representation in its public constituencies. The Trust has allocated resources for the employment of a Membership and Engagement Manager who will be responsible for devising strategies to address these gaps, and making recommendations for updating its Membership Development and Communications Strategy.

Legality of Constitution
In November 2008, the Trust made approved changes to its Constitution which include changing to an opt-out scheme for staff membership, removing the disqualification of volunteers from staff membership, clarifying the strategies to be taken into account in the non-executive director appointment policy and listing the major nursing and education providers from which a Partner Council Member may be appointed. On 2 April 2009, the Trust corrected an unapproved change in the recent constitutional amendments.

A copy of the approved constitution along with confirmation of the approval of amendments and compliance with National Health Service Act 2006 is published on the Trust's website: http://www.chelwest.nhs.uk/foundationtrust/keyDocument/index.html

As a result of recent changes to the Constitution with respect to changing to an opt-out scheme for staff membership, the Trust has identified a risk of not complying with its Constitution in relation to registration and, effectively, representation of what it assesses as a very small number of persons likely to be eligible for membership of the staff constituency. Options to mitigate will be discussed at the Members' Council meeting on 18 June 2009. The Trust does not view this as a significant risk.

Appropriate Board Roles and Structures with a Collaborative Relationship between the Members' Council and the Board of Directors
There have been no changes to the Board of Directors in 2008/09. The Board hosts a joint Away Day and attends quarterly general meetings of the Members' Council to better understand the views of the Members' Council. The Board enjoys a collaborative relationship with its Members' Council which is evidenced by the support of the Members' Council in responding to external service development proposals such as the consultation on stroke services.

Service Performance (Targets and National Core Standards)
The Trust has experienced a good year and we expect to be scored as fully met on all national targets. Thresholds for the HES maternity data completeness indicator will be published in October 2009. Our performance is 94.3%, London is 80.1% and nationally the score is 78.5%. Therefore we expect to receive three points out of three when the thresholds are published.

The Trust considers key performance risks in 2009/10 lie with the following targets:

- Maximum waiting time of 14 days from decision to treat to start of treatment extended to cover cancer treatments.
- 18-week maximum wait by 2008 (90% threshold for admitted patients and 95% for non-admitted patients) at specialty level.

For both of these areas a risk assessment has been completed and plans are either in place or being put in place to mitigate key risks.

Clinical Quality
Effective arrangements are in place to monitor and continually improve the quality of healthcare (including patient safety) provided to the Trust's patients. More information on quality is detailed under section 2.2.4.

Effective Risk and Performance Management
The Trust has effective mechanisms in place to manage risk which are outlined in the Risk Management Policy and Strategy. Reports on the management of risk are received through the Audit Committee and the Assurance Committee. Progress on objectives and meeting of risks associated with objectives and other significant risks are also presented to the Board quarterly as well as an Annual Risk Management Report. A draft compliant Statement of Internal Control (SIC) for 2009/10 is also in place.

Cooperation with NHS Bodies and Local Authorities
Relationships with all partner organisations remain positive and the Trust is actively involved with national and London NHS bodies as well as the local community.

As a new organisation we will have to determine our collaborative arrangements with them but do not perceive any risks in this area as we have been dealing with the PCTs on an individual basis previously.

The Trust also has a good relationship with its key local authority, the Royal Borough of Kensington and Chelsea and is committed to working closely with the authority's Overview and Scrutiny Committee for Health. The Trust is represented on a number of local authority committees including the Local Safeguarding Children Board and the Children and Young People's Partnership Boards of the Royal Borough of Kensington and Chelsea and the London Borough of Hammersmith and Fulham.

3.1.2 Significant Risks
There are no significant risks to governance anticipated for 2009/10.

3.1.3 HCAI Targets

		Q1	Q2	Q3	Q4
MRSA	2008/09 target	4	5	5	5
	2008/09 actual	2	2	0	1
	2009/10 target	4	5	5	5
C. difficile	2008/09 target	18	22	35	39
	2008/09 actual	9	12	7	13
	2009/10 target	18	22	33	36

3.2 Mandatory Services Risk

The Chelsea and Westminster Hospital NHS Foundation Trust anticipates that it will retain its **green** mandatory services risk rating for 2009/10.

3.2.1 Commentary on Mandatory Services Risks
The Trust does not anticipate any changes to its mandatory services in 2009/10.

3.2.2 Significant Risks
There are no significant risks to mandatory services anticipated for 2009/10.

3.3 Financial Risk

3.3.1 Commentary on Financial Risk Rating
Commentary on the financial risk rating is detailed in section 3.2.

3.3.2 Significant Risks
The Trust has considered a number of downside scenarios for the 3-year period and has developed mitigating options to ensure that the Trust can continue to deliver an excellent rating for use of resources and quality of services.

The key risks and mitigations for 2009/10 are summarised in the following table:

Risk	Mitigation	Magnitude (5 = worst)	Likelihood (5 = most likely)
Cost improvements are not delivered	Alternative schemes are developed to ensure the total value of CIPs is achieved. A programme of management approach is being taken to ensure savings schemes are planned and monitored effectively (including the establishment of clinical coding and procurement groups).	3	3
Agency staff are not reduced	The Trust is planning to reduce agency costs through a combination of substantive appointments to deliver activity increases, introducing a specialist bank rate to incentivise staff to transfer from agencies, robust monitoring of agency costs supported by the introduction of a quota system and reducing the number of agencies it contracts with.	3	2
Activity increases are not delivered reflecting competition from other providers and lower growth in referrals	Costs of delivering activity are included in the plan, and in the event activity and income increases are not delivered, reduced costs will offset reduced income. The impact of commissioner planning intentions has been reflected in plans.	3	1
Significant contracts are due for retender and may exceed estimates	The Trust has contingencies to offset any unexpected costs.	2	2

In addition, the Board of Directors has considered a sensitivity analysis of a number of downside risks beyond 2009/10 and reviewed mitigation strategies to ensure the Trust delivers a satisfactory Financial Risk Rating.

3.4 Risk of Any Other Non-Compliance with Terms of Authorisation

The Trust does not anticipate any other significant risks to its Authorisation.

4. DECLARATIONS AND SELF-CERTIFICATION

4.1 Self-Certification

In order for the Board of Directors to be assured that the Board Statements are true, a review of evidence for self-certification was undertaken and presented to the Board. The Board was satisfied that it fully complied with the Board Statements and the self-certification was signed by the accounting officer (the chief executive) and the chair.

4.2 Board Statements

The Board of Directors confirms that the following statements are true.

For clinical quality, that:

- ☑ The board is satisfied that, to the best of its knowledge and using its own processes (supported by relevant Quality Care Commission metrics and including any further metrics it chooses to adopt), its NHS foundation trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients; and
- ☑ The board will self-certify annually that, to the best of its knowledge and using its own processes, it is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.

For service performance, that:

- ☑ The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) and national core standards, and a commitment to comply with all known targets going forwards.

For other risk management processes, that:

- ☑ Issues and concerns raised by external audit and external assessment groups (including reports for NHS Litigation Authority assessments) have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in a timely manner;
- ☑ All recommendations to the board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned;
- ☑ The necessary planning, performance management and risk management processes are in place to deliver the annual plan;
- ☑ A Statement of Internal Control ('SIC') is in place, and the NHS foundation trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to most up to date guidance from HM Treasury;
- ☑ The trust has achieved a minimum of Level 2 performance against the requirements of their Information Governance Statement of Compliance (IGSoC) in the Department of Health's Information Governance Toolkit; and
- ☑ All key risks to compliance with the Authorisation have been identified and addressed.

For compliance with its Authorisation, that:

- ☑ The board will ensure that the NHS foundation trust remains at all times compliant with the Authorisation and relevant legislation;

☑ The board has considered all likely future risks to compliance with its Authorisation, the level of severity and likelihood of a breach occurring and the plans for mitigation of these risks; and

☑ The board has considered appropriate evidence to review these risks and has put in place action plans to address them where required to ensure continued compliance with its Authorisation.

For board roles, structures and capacity, that:

☑ The board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the board;

☑ The board is satisfied that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability;

☑ The selection process and training programmes in place ensure that non-executive directors have appropriate experience and skills;

☑ The management team have the capability and experience necessary to deliver the annual plan; and

☑ The management structure in place is adequate to deliver the annual plan objectives for the next three years.

Signature: _____ Signature: _____

In capacity as Chief Executive and Accounting Officer

in capacity as Chairman

Signed on behalf of the Board of Directors and having regard to the views of the Members' Council.

5. MEMBERSHIP

5.1 Membership Report

Table 5.1: Membership size and movements

	2008/09	2009/10 (est.)
Total membership		
At year start (April 1)	13,140	15,438
New Members	3,104	1,086
Members Leaving	805	779
At year end (31 March)	**15,438**	**15,745**
Public constituency		
As at start (April 1)	6,580	6,372
New Members	195	436
Members leaving	403	436
At year end (March 31)	**6,372**	**6,372**
Staff Constituency		
As at start (April 1)	495	2,930
New Members	2,476	0
Members leaving	11	0
At year end (March 31)	**2,930**	**2,930**
Patient constituency		
As at start (April 1)	6,095	6,136
New Members	433	650
Members leaving	392	343
At year end (March 31)	**6,136**	**6,443**

Table 5.2: Analysis of current membership (as at 31 March 2009)

	Number of members	Eligible membership *
Public constituency		
Age (years):		
0-16	1	127,076
17-21	66	41,156
22+	5,461	771,257
Unknown	844	
Public constituency		
Ethnicity:		
White	4,556	589,219
Mixed	245	29,013
Asian or Asian British	342	49,221
Black or Black British	280	68,025
Other	309	204,011
Unknown	640	
Public constituency		
Socio-economic groupings:		
ABC1	5,528	598,056
C2	2	
D	0	43,873
E	829	
Unknown	13	297,560
Public constituency		
Gender Analysis:		
Male	2,550	367,501
Female	3,779	398,326
Unknown	43	173,662
Patient constituency		
Age (years):		
0-16	1	46,000
17-21	64	24,000
22+	6,071	448,000

* The figures for eligible membership are based on the Office for National Statistics table resident population estimates for mid 2005 as well as the 2001 Census data.

5.2 Membership Commentary

The total membership of the Trust was 15,438 members at 31 March 2009 drawn from public, patient and staff constituencies, each having its own eligibility rules though all members are required to be at least sixteen (16) years old.

5.2.1 Constituencies and Commentary on Changes in Membership Numbers

Overall, the membership grew by 18% in 2008/09 falling short of the target of 20%.

The public constituency comprises those members that live in one of the following four public constituencies: the Royal Borough of Kensington and Chelsea, the London Borough of Hammersmith and Fulham, the London Borough of Wandsworth and the City of Westminster.

The target growth for this constituency in 2008/09 was 0%; however, there was negative growth in this constituency as recruitment did not match leavers.

The patient constituency comprises members who are patients, or carers of patients, who have attended the hospital during the last three years.

The patient's constituency was planned to grow by 5% in 2008/09 in line with recruitment. Actual growth realised was 0.7%.

The staff constituency is divided into six classes: Support, Administrative and Clerical; Allied Health Professionals: Scientific and Technical; Contracted; Medical and Dental; Nursing and Midwifery and Management.

The staff constituency is open to both employees (subject to the requirement to hold a contract of either no fixed term or for a minimum of 12 months or to have been continuously employed for 12 months) and other individuals who continually exercised functions for the purposes of the Trust for at least 12 months.

The target growth rate for 2008/09 was 496% based on changing the constitutional provisions to a default position of automatic membership. The actual growth was 530%, the number of members opting out was minimal and the Trust exceeded its target for this constituency.

5.2.2 Target Levels of Representation

The Trust also addresses qualitative factors and the need for membership of the public constituency to be representative of the communities which it serves. The Members' Council Development and Communications Sub-Committee commissioned an analysis of its public constituency in February 2009. Based on the findings of the work done by Computershare, the Members' Council has identified three areas for further development:

Geographical

Penetration in the Wandsworth One sub-constituency was significantly below the benchmark of 1% of the local population. This includes the catchment area of Earlsfield, Fairfield, Roehampton, Southfields, Thamesfield, Tooting, Wandsworth Common, Westhhill and West Putney.

Age

The distribution of the membership in the under-40 age group was significantly lower than the general population; however, the trend reversed past the age of 40.

Socio-Economic Groups

Based on profiling by postcode, the distribution of the Trust's membership is significantly higher in the lowest social group (E) than in the general population and is significantly lower in the highest

social group (A).

5.2.3 Review by Board of Directors

The Board of Directors and the Members' Council have a good relationship with open communications. The Chairman (who also chairs the Members' Council) presents a monthly report to the Board which updates them on membership and the work of the Members' Council and its sub-committees in relation to topics such as growth and engagement.

5.2.4 Recruitment and Engagement – the Past 12 Months

In developing the Annual Plan for 2008/09, it was recognised that costs of recruitment had been under-estimated in previous years and a number of initiatives had been agreed to secure target growth rates. These included:

a) Developing leaflets and display stands in line with the Chelsea and Westminster brand;
b) Two (2) week long recruitment campaigns in advance of Open Day and the Annual Members' Meeting;
c) Development of an 'Information Zone' with a 60-inch plasma screen and electronic kiosks; and
d) An application form in discharge booklets.

A generous proportion of the Members' Council budget was allocated to projects to promote membership development and communications in support of the Annual Plan.

5.2.5 Steps Planned in the Next Twelve Months

The Trust's targets for 2009/10 are set not in relation to local population benchmarks, rather in relation to actual achieved growth in 2008/09. The Trust is operating in a rapidly changing provider environment with a risk of a severe down turn in public finances. Recruitment must be constrained by value-for-money considerations.

The Trust will focus in 2009/10 on achieving sustainable growth and on the retention of existing members as well as the recruitment of new ones.

The most critical challenge is the public constituency where the default method of joining is opt-in. Our public constituency benchmark is 9,395 members in keeping with 1% of the Office of National Statistics resident population estimates for mid-2005. The Trust does not believe that it can significantly increase numbers in the public constituency over a three-year term as this will overwhelm the operational and financial capacity of the Trust. Benchmarking of the constituency over a three-year period will require recruitment of more than 1,333 public members in the 2009/10 financial year compared to 195 new members recruited in the year under review.

The Trust's target is to maintain the size of the membership in the public constituency in 2009/10. There are now more foundation trusts in London competing for members and it is now much more difficult and costly to recruit new members.

In the patient constituency, the Trust aims for growth of 5% through the continued use of its new discharge leaflet which was developed in late 2008. The feedback received is that this method has been successful and the Trust will attempt to ensure that every patient discharged receives a leaflet. The Trust expects to see the full-year effect of this method in 2009/10.

The Trust embarked on a number of initiatives in the year under review to develop its branding and engage its membership and expects to see the rewards in 2009/10 when it completes the development and refurbishment of its Information Zone within the hospital in 2009/10. This will become a dedicated area equipped with electronic kiosks to promote communication with members.

The Trust is recruiting a dedicated Engagement and Membership Manager with responsibility for developing the communications and engagement strategy. The Trust will also use its Seasonal Working Conferences, Patients' Panels and links with the Patient Advice and Liaison Service to network and develop the membership.

The Trust will also continue to promote two week long membership recruitment campaigns which usher in Open Day and the Annual Members' Meeting.

Approximately 60% of Council Members seats will become vacant in the autumn as some of the original Council Members come to the end of their term. The election will be an opportunity for the Trust to generate another wave of interest in membership when it invites nominations for the various vacant seats in the autumn. The Trust will encourage nominees who are able and willing to network in their communities and support its newly-elected Council Members by means of a comprehensive induction in articulating the case for a representative membership.

5.2.6 Elections

In the last year, 2008/09, an election was conducted in accordance with the rules of the constitution in the public constituency Kensington and Chelsea Area Two to fill the seat vacated by Valerie Arends. Lady Sandra Smith-Gordon was elected. The turnout was 15.8%.

Table 5.3: Analysis of election turnout

Date of election	Constituencies Involved	Number of members in constituency	Number of seats contested	Number of contestants	Election turnout %
24/08/2008	Kensington & Chelsea Area 2	2029	1	3	15.8%

APPENDIX 1: INFLATION ASSUMPTIONS

	2009/10	2010/11	2011/12
National CIP efficiency target	3.00%	3.50%	4.00%
INCOME ASSUMPTIONS			
Clinical Income NHS			
PbR Tariff Inflation	1.70%	1.20%	-1.60%
Non PbR Clinical Income Inflation	1.70%	1.20%	-1.60%
Clinical Income Private Patients			
Private Patients Income Inflation	2.20%	1.20%	0.70%
Research & Development			
R&D Inflation	2.20%	1.20%	0.70%
Education & Training			
Education & Training Inflation	2.20%	1.20%	0.70%
Other income			
Other Income Inflation	2.20%	1.20%	0.70%
COST ASSUMPTIONS			
Pay Costs			
Salary Inflation	2.40%	2.25%	2.00%
Medical Salaries	1.00%	2.00%	2.00%
National Insurance Increase	0.00%	0.00%	0.50%
Drug Price Inflation	0.00%	0.00%	0.00%
Other Costs			
Other Cost Inflation	0.50%	2.00%	2.00%

APPENDIX 2: INCOME BRIDGING STATEMENT

£m	2008/09 Outturn	2009/10 Plan	2010/11 Plan	2011/12 Plan
NHS Clinical Income	**233.2**	**253.6**	**261.7**	**253.7**
Year-on-Year Change		**20.3**	**8.1**	**(8.0)**
HRGv4		6.3	0.0	0.0
Market Forces Factor		(6.8)	(2.1)	(2.3)
Other Tariff Changes		(0.4)	1.4	(0.2)
Activity & Investment:		0.0	0.0	0.0
Specialist Paediatrics		0.0	4.7	(0.1)
Urgent Care Centre		0.0	(1.1)	(2.2)
NICU & Maternity		4.9	0.6	0.0
Other Growth and Investment		11.3	1.2	0.9
Inflation		4.0	3.0	(4.1)
Cost Improvement Plans		2.7	0.1	0.0
Other		(1.7)	0.3	0.0
Non-NHS Clinical Income	**10.2**	**10.2**	**10.2**	**10.2**
Year-on-Year Change		**(0.0)**	**(0.1)**	**0.1**
Inflation		0.2	0.1	(0.2)
Other		(0.2)	(0.2)	0.3
Education & Training	**22.7**	**22.8**	**21.6**	**20.5**
Year-on-Year Change		**0.1**	**(1.1)**	**(1.2)**
Reduction in MADEL Flex WTE		(0.1)	0.0	0.0
MPET Review		0.0	(1.3)	(1.3)
Reduction in Number of SIFT placements and Training Management Supplement		(0.3)	0.0	0.0
Inflation		0.5	0.3	0.1
Other		(0.0)	(0.1)	0.0
Research & Development	**2.7**	**4.0**	**3.4**	**4.4**
Year-on-Year Change		**1.4**	**(0.6)**	**1.0**
Non recurrent R&D Transitional Funding		1.1	(1.1)	0.0
CLAHRC & Commercial R&D		1.6	0.4	0.9
Inflation		0.1	0.1	0.1
Cessation of Culyer Funding		(1.7)	0.0	0.0
Other		0.2	0.0	0.0
Misc Other Operating Income	**11.9**	**17.3**	**17.5**	**17.9**
Year-on-Year Change		**5.4**	**0.3**	**0.4**
Cost Improvement Plans		0.7	1.0	0.5
Activity related income		0.8		
Inflation		0.3	0.2	0.1
Other		3.6	(0.9)	(0.2)

APPENDIX 3: EXPENDITURE BRIDGING STATEMENT

£m	2008/09 Outturn	2009/10 Plan	2010/11 Plan	2011/12 Plan
Pay Costs	**148.1**	**160.0**	**163.3**	**163.1**
Year-on-Year Change		**11.9**	**3.3**	**(0.2)**
Business Cases		2.7	2.4	0.0
Cost Pressures		2.2	0.0	0.0
Activity		5.5	1.4	0.0
Inflation		3.5	3.1	3.9
Cost Improvement Plans		(2.0)	(3.6)	(4.2)
NHS Training for Innovation		0.2	0.0	0.1
Other		(0.2)	(0.0)	0.0
Drug Costs	**43.0**	**47.0**	**47.3**	**46.8**
Year-on-Year Change		**4.0**	**0.3**	**(0.5)**
Growth		2.6	0.0	0.0
Cost Pressures		2.2	0.0	0.0
Business Cases		0.0	0.1	0.0
Inflation			0.9	0.9
Non recurrent VAT saving		(0.7)	0.7	0.0
Cost Improvement Plans		(0.1)	(0.5)	(0.5)
Other		(0.0)	(0.9)	(0.9)
Clinical supplies & services	**28.0**	**32.0**	**31.4**	**30.4**
Year-on-Year Change		**4.0**	**(0.6)**	**(1.0)**
Growth		1.5	0.1	0.0
Inflation		0.1	0.5	0.5
Business Cases		0.0	0.6	0.0
Cost Pressures		0.3	0.0	0.0
Cost Improvement Plans		(0.9)	(1.8)	(1.5)
Other		3.0	0.0	0.0
Other Operating Expenses	**35.1**	**42.2**	**39.2**	**34.6**
Year-on-Year Change		**7.1**	**(3.0)**	**(4.6)**
Release of provisions offset by exceptionals		2.2	0.0	0.0
Energy		(0.3)	(0.3)	(0.3)
CNST		1.7	0.0	0.0
Property costs- Dean Street, Cavaye Place		1.4	0.0	0.0
Facilities contracts & maintenance		2.2	0.0	0.0
NHS Training for Innovation		0.5	0.1	(0.1)
Business Cases/Cost Pressures/Inflation		0.6	0.7	0.4
Cost Improvement Plans		(1.9)	(3.6)	(4.2)
Other		0.7	0.1	(0.4)
Depreciation & Interest	**16.9**	**20.2**	**23.3**	**25.5**
Year-on-Year Change		**3.3**	**3.1**	**2.2**
Depreciation		1.6	1.9	1.8
Interest Payable		(0.1)	0.6	0.0
Interest Receivable		1.4	0.0	0.0
Dividends		0.5	0.6	0.4
Other		(0.1)	0.0	0.0

APPENDIX 4: THREE YEAR CAPITAL PROGRAMME

£'000s	2009/10	2010/11	2011/12
Capacity Expansion			
Specialist Paediatrics Theatres	7,112	3,357	0
Specialist Paediatrics PICU/Wards	303	7,437	2,666
Specialist Paediatrics New Outpatient Areas	1,285	757	0
Medical Equipment for capacity expansion	2,000	3,500	0
HIV Ward Development	1,597	2,418	0
Burns Development	3,100	0	0
Additional Office Accommodation	2,479	0	0
Other clinical capacity expansion	1,192	1,071	73
Subtotal	19,069	18,540	2,739
Condition Maintenance of Property, Plant and Equipment			
Medical Equipments replacement	1,250	1,250	1,250
IM&T Hardware/Software replacement	683	320	320
Backlog Maintenance/Plant Upgrade	3,520	3,063	2,465
Other	1,666	955	500
Subtotal	7,119	5,588	4,535
IM&T Developments			
Security/Single Sign On	643	0	0
NHS Number Adoption	1,128	0	0
Inpatient Prescribing	637	0	0
Other IM&T Developments	2,708	2,860	2,100
Subtotal	5,116	2,860	2,100
Clinical Space Development			
Development of Endoscopy/ Radiology/ Cardiology space	588	1,180	
Conversion of 2 wards to 50% Single Rooms	0	2,700	2,700
Other clinical space development	1,220	0	0
Subtotal	1,808	3,880	2,700
Other Clinical Developments			
Medical Equipment investment	1,364	0	0
Urgent Care Centre/Other	253	1,000	1,500
Subtotal	1,617	1,000	1,500
Other Minor Projects	773	300	300
Grand Total	**35,502**	**32,168**	**13,874**

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 18 June 2009

AGENDA ITEM NO.	3.3/Jun/09
PAPER	a) Letter dated 20th April 2009 b) Consultation – Guide for NHS Trust Governors: Meeting your statutory responsibilities c) Feedback Form
AUTHOR	Monitor
LEAD	Prof. Sir Christopher Edwards, Chairman
EXECUTIVE SUMMARY	The enclosed draft document for consultation, *Guide for NHS foundation trust governors: meeting your statutory responsibilities* is intended to provide governors with: • clarity in regard to statutory duties; • suggestions as to effective processes that could be followed in order to deliver these duties; and • insight into how other NHS foundation trusts approach the same challenges. The consultation period runs for 12 weeks and closes at **5pm on Monday 13 July 2009**.
DECISION/ ACTION	The Members' Council is note the paper.

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20 April 2009

Dear colleague

Guide for NHS foundation trust governors: meeting your statutory responsibilities

A key part of NHS foundation trust policy is its unique form of local accountability and governance. When creating NHS foundation trusts, Parliament and the Government were clear that there had to be both a strong local voice and a strong regulator to ensure that trust boards were held to account, patients received the highest quality of care and taxpayers received best value for money. This was the basis upon which Ministers proposed to remove themselves from direct involvement in the running of hospitals to create NHS foundation trusts.

Since the first NHS foundation trusts were authorised five years ago, we have gained a good deal of knowledge about how the governance structures are developing. We built upon this understanding in late 2007 through a survey of over 1,300 governors. The results told us that although most governors were getting to grips with their role, there is a clear need for further guidance and support.

The role of the governor is pivotal in delivering robust governance in foundation trusts. This legitimacy is gained directly from the statutory duties and responsibilities that legislation provides. As the regulator we believe it is important that governors have as much clarity as possible, particularly around their statutory duties.

The enclosed draft document for consultation, *Guide for NHS foundation trust governors: meeting your statutory responsibilities* is intended to provide governors with:

- clarity in regard to statutory duties;
- suggestions as to effective processes that could be followed in order to deliver these duties; and
- insight into how other NHS foundation trusts approach the same challenges.

The consultation period runs for 12 weeks and closes at **5pm on Monday 13 July 2009**. We welcome feedback using the response form attached below. A copy of this letter, the draft guide and response form are available on our website: www.monitor-nhsft.gov.uk

Yours faithfully

Dr William Moyes
Executive Chairman

Consultation questions on *Guide for NHS foundation trust governors: meeting your statutory responsibilities*

We welcome feedback on this draft document.

This consultation launched on Monday 20 April 2009 and runs for 12 weeks. Please submit your responses by 5pm, Monday 13 July 2009.

Below are the consultation questions. You can find these on our website and respond in any of the following ways:

1. **Online:**

- by completing the online form on our website: **www.monitor-nhsft.gov.uk/governors-consultation**

2. **Email:**

- by saving this document and then emailing your responses to **consultation@monitor-nhsft.gov.uk**; or

- by downloading a document containing the questions from our website (**www.monitor-nhsft.gov.uk/governors-consultation**) and then emailing your responses to **consultation@monitor-nhsft.gov.uk**

3. **Post:**

- by sending your responses to the following address:

  Consultation on Guide for Governors
  Monitor
  4 Matthew Parker Street
  London
  SW1H 9NP

4. **Fax:**

- by faxing your responses to **020 7340 2401.**

We will publish the results of the consultation. If you would prefer for your identity not to be included within the published results, please tick here ☐

Contact details:

Full name:	
Job title or role (eg governor):	
Organisation:	
Nature of organisation (for example, foundation trust):	
Address:	
Telephone number:	
Email:	

Consultation questions:

The governance structure within NHS foundation trusts

1. Does the chapter on governance structure explain in principle the key elements of a foundation trust? If not, which elements require further explanation?

2. Are there other useful committees/roles you feel should be covered in this section? Are the terms used in the guide clear?

The role of a governor

3. Are the statutory duties of the board of governors explained clearly? If not, how would you improve this?

The governors and the chair (and non-executive directors)

4. Do you agree that governors should be involved in performance appraisals for the chair and non-executive directors? If not, what information should governors have when considering issues such as re-appointment or removal?

5. Was the process for appointing a chair sufficiently clear? If not, what additional elements or clarification would be helpful?

6. Does the guide provide clarity over setting terms and conditions for all non-executive directors, including the chair? If not, what further guidance would aid the process?

7. Do you agree with the suggested process for removal?

Approving the appointment of the chief executive

8. Is the process for approving the appointment of the chief executive clear? If not, how would you improve this?

The governors and the NHS foundation trust auditor

9. Does the chapter on appointing and removing the auditor explain the key requirements of the board of governors? What additional information would be helpful?

Receiving the NHS foundation trust's accounts

10. Does this chapter provide useful guidance for governors? Is further explanation required?

The forward plan

11. Is the board of governors' role in preparing the forward plan clearly explained in the guidance?

General

12. Is the guide written in a concise and clear manner?

13. Are the statutory duties of the board of governors clearer to you after reading the guide?

Monitor

Independent Regulator
of NHS Foundation Trusts

Guide for NHS foundation trust governors: meeting your statutory responsibilities

A draft document for consultation

Table of contents

Introduction

Since the first NHS foundation trusts were authorised in 2004, the concept of providing a health service driven by, and accountable to, the local community has gained momentum with significant membership growth and an active governor body involved in shaping direction and strategy.

Governors do not undertake operational management of NHS foundation trusts; rather they challenge the board of directors and collectively hold them to account for the trust's performance. It is also the governors' responsibility to represent their members' interests, in particular with regards to the strategic direction of the trust. Legislation provides governors with statutory responsibilities to deliver these key objectives.

In 2007, Monitor, the Independent Regulator of NHS Foundation Trusts, embarked on research to find out, from governors themselves, how well this unique system of governance was working – how engaged governors felt in their organisations, the effectiveness of communications with Chairs and boards of directors and crucially how governors were exercising their statutory duties.

As the regulator we are concerned not only that the governance system of an NHS foundation trust is operating in a way that is compliant with the law, but that governors have the knowledge, support and resources to enable them to add maximum value to their organisations. The findings of the survey told us that, in the area of the discharging of statutory duties, governors would welcome further guidance and support.

Those findings underpin this guide, which looks at what the statutory powers and duties of governors are, what is required of governors in relation to them and in practice how governors can best meet these challenges.

1 The governance structure within NHS foundation trusts

This chapter describes the role of the board of governors in the context of the overall structure of an NHS foundation trust.

Issues that we will look at in this chapter include:

- NHS foundation trusts in general terms;
- the governance structure of an NHS foundation trust; and
- the regulation of foundation trusts.

What are NHS foundation trusts?

NHS foundation trusts provide healthcare according to core NHS principles – free care, based on need and not ability to pay.

They are free from central government control and have the freedom to make decisions for themselves. Nevertheless, they are subject to statutory requirements and all have a duty to exercise their functions effectively, efficiently and economically.

At the heart of the model is the element of local accountability, in relation to which governors perform a pivotal role. Governors are comprised of elected and appointed individuals who represent members and other stakeholder organisations through a board of governors. They are the individuals that bind a trust to its patients, staff and stakeholders.

The National Health Service Act 2006 gives governors various powers that are statutory responsibilities. It is primarily these mandatory responsibilities that this guide seeks to explore further.

What is the governance structure of an NHS foundation trust?

Each NHS foundation trust has its own governance structure. The key document in this regard is the foundation trust's constitution, which is published in the NHS foundation trust directory on Monitor's website: www.monitor-nhsft.gov.uk.

Although each constitution will be unique to the NHS foundation trust it relates to, there are legal requirements that apply to all NHS foundation trusts. The requirements are set out in Monitor's *Model Core Constitution,* on which all NHS foundation trust constitutions must be based. In addition to the formal statutory requirements, Monitor has also issued best practice advice on governance in *The NHS Foundation Trust Code of Governance*. NHS foundation trusts are required to explain any non-compliance with the *Code of Governance*. This guide should be read as best practice advice complementing the *Code of Governance.*

The basic governance structure of all NHS foundation trusts includes:

1. The membership;
2. The board of governors; and
3. The board of directors.

In addition to this basic structure, NHS foundation trusts will also make use of board committees and working groups, comprising both governors and directors, as a practical way of dealing with specific issues. Some committees (appointments, remuneration and audit) are required by legislation and others are referred to in the *Code of Governance* and elsewhere.

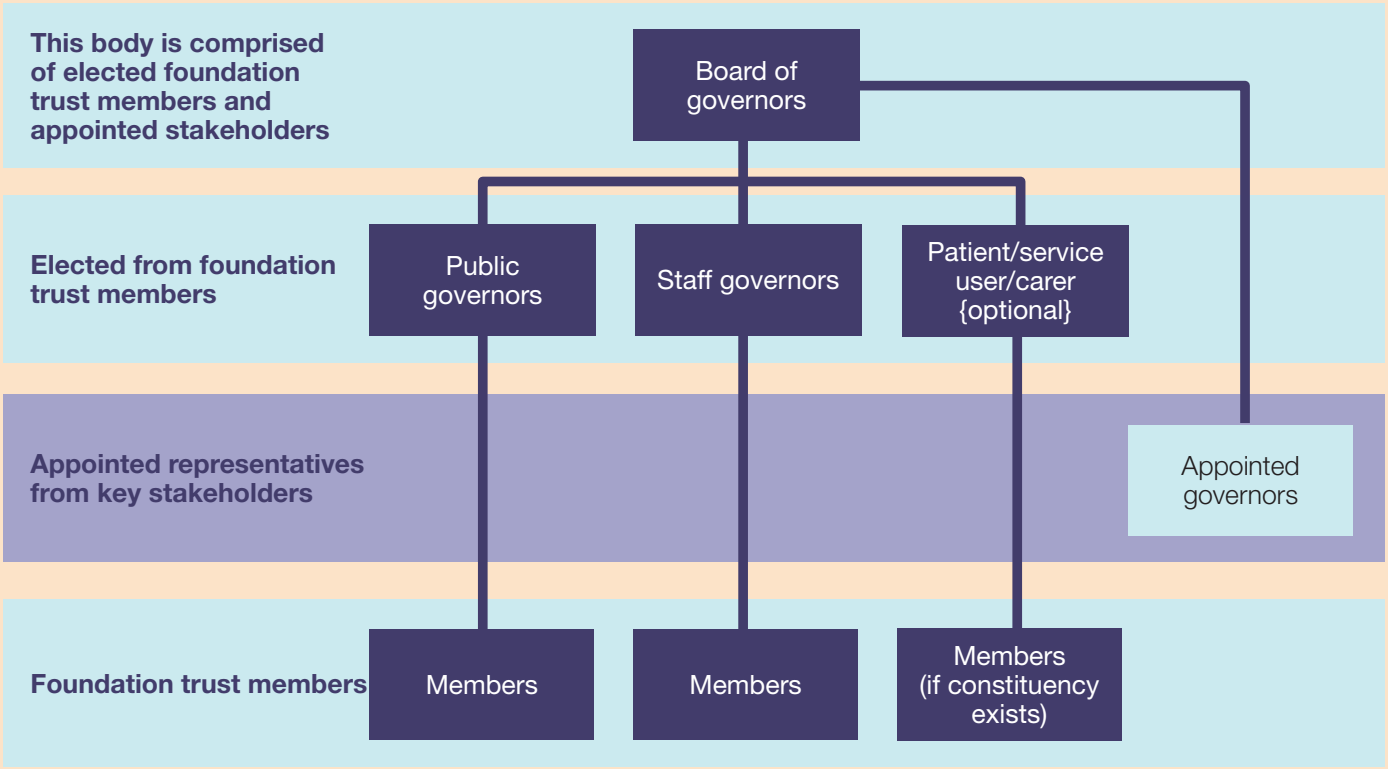


Figure 1: Illustration of a board of governors

"For every new governor, we hold a skills and experience audit. This maximises the contribution the individual can make and from this governors are assigned to the various committees and working groups"

Membership

The membership consists of staff and the general public and optionally patients or service users and their carers. Members belong to various constituencies as defined in each NHS foundation trust's constitution. Members in the various constituencies vote to elect governors and can also stand for election themselves. An NHS foundation trust must have a public constituency and a staff constituency, and may also have a patient or service users' constituency.

Board of governors

The diagram on page 5 illustrates the composition of a typical board of governors. The board of governors of an NHS foundation trust is comprised of elected NHS foundation trust members and appointed individuals or representatives from other key stakeholders.

The legislation requires that the board of governors has appointed representatives from certain key stakeholders, such as a primary care trust that commissions services from the NHS foundation trust, and a local authority.

In addition to the appointed governors referred to above, the NHS foundation trust's constitution will set out key stakeholders that are entitled to appoint representatives to the board of governors. Such stakeholders include, for example, local voluntary groups, trade unions or charities.

The Chair of the board of directors is also the Chair of the board of governors. This is a legal requirement.

Several NHS foundation trusts have elected not to use the term "board of governors" and various alternatives are used including:

- council of governors;
- membership council;
- members' council; and
- governors' body.

Board of directors

The NHS foundation trust board of directors is responsible for all aspects of the performance of the NHS foundation trust. All the powers of the NHS foundation trust are exercisable by the board of directors on its behalf. The board of directors will have executive and non-executive directors and should include a balance of each. Additionally, the *Code of Governance* recommends that a majority of the board of directors be independent non-executive directors.

Executive directors

The executive directors must include a Chief Executive (who is also the accounting officer) and a finance director.

In addition, one of the executive directors must be a registered medical practitioner or dentist and one must be a registered nurse or midwife.

Non-executive directors and the Chair

The non-executive directors will include the Chair. A person may only be appointed as a non-executive director if he/she is a member of the public constituency (or the patients' constituency where there is one). Where the trust has a university medical or dental school, he/she exercises functions for that university.

Under Monitor's *Code of Governance*, the board of directors should identify each non-executive director it considers to be independent. The test of independence assesses whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement. Further detail in relation to what constitutes independence is provided in the *Code of Governance.*

"Our Nominations Committee for the appointment of the Chair and non-executive directors comprises 60% elected governors and 40% non-executive directors. This mix allows a good exchange of information about the specific role required"

Committees

The key committees included in this guide are set out below.

Nominations committee

The nominations committee or committees will be responsible for the identification and nomination of executive and non-executive directors.

The *Code of Governance* states that there may be one or two nominations committees. If there are two, one will be responsible for dealing with nominations for executive directors and the other for dealing with nominations for non-executive directors (including the Chair). The Chair of the NHS foundation trust or an independent non-executive director should chair the committees.

Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the non-executive directors should consist of a majority of governors. If only one nominations committee exists, when nominations for non-executive appointments, including the Chair appointment, are being discussed, the composition should ensure there is a majority of governor votes.

One nominations committee

- a committee of the board of directors
- responsible for identification and nomination of both executive and non-executive directors
- when considering non-executive appointments, the nominations committee must ensure appropriate governor involvement, potentially through a governors working group focused on non-executive appointments
- the trust should bear in mind the desirability of ensuring a majority of governors votes for all non-executive nominations

Two nominations committees

- one nominations committee is focused solely on the nomination of executive directors – governor involvement is welcomed
- the second nominations committee is focused solely on non-executive nominations and should consist of a majority of governors, though appropriate consultation with the executive directors must take place
- in this scenario, a governor working group is unlikely to be required

Figure 2: Options for nominations committees

Audit committee

The audit committee is responsible for monitoring and reviewing matters such as the integrity of financial statements of the NHS foundation trust, the NHS foundation trust's internal financial controls and the internal audit function.

The audit committee must consist of non-executive directors and is appointed by the board of directors. The *Code of Governance* states that the committee should have at least three independent non-executive directors and that at least one member of the audit committee should have recent and relevant financial experience.

Governors are not members of the audit committee. However, under the *Code of Governance*, the audit committee should report to the board of governors identifying any matters where it considers action or improvement is needed and making recommendations on the steps to be taken.

Remuneration committee

The board of directors must establish a remuneration committee composed of non-executive directors. This committee has responsibility for setting the terms and conditions of office, including remuneration (pay and benefit entitlements) and allowances of the executive directors.

The remuneration committee does not have a direct role in relation to the terms and conditions of the Chair and the other non-executive directors. Responsibility here lies with the board of governors.

Other useful roles in the governance structure

In addition to the key statutory roles of the Chair and Chief Executive, there are other positions suggested in the *Code of Governance* and elsewhere as being highly significant to the efficient and effective running of an NHS foundation trust.

Deputy Chair

The *Model Core Constitution* recommends that an NHS foundation trust's constitution provides for a deputy Chair. The deputy Chair will be one of the NHS foundation trust's non-executive directors and should deputise for the Chair as and when appropriate.

Senior independent director (SID)

The *Code of Governance* states that one of the independent non-executive directors should be appointed by the board of directors as the "senior independent director". This appointment should be made in consultation with the board of governors. The SID should act as the point of contact if governors have concerns which contact through normal channels has failed to resolve or for which such normal contact is inappropriate.

Further details in relation to the role of the senior independent director and what "independent" means can be found in the *Code of Governance*.

Vice-Chair of the board of governors

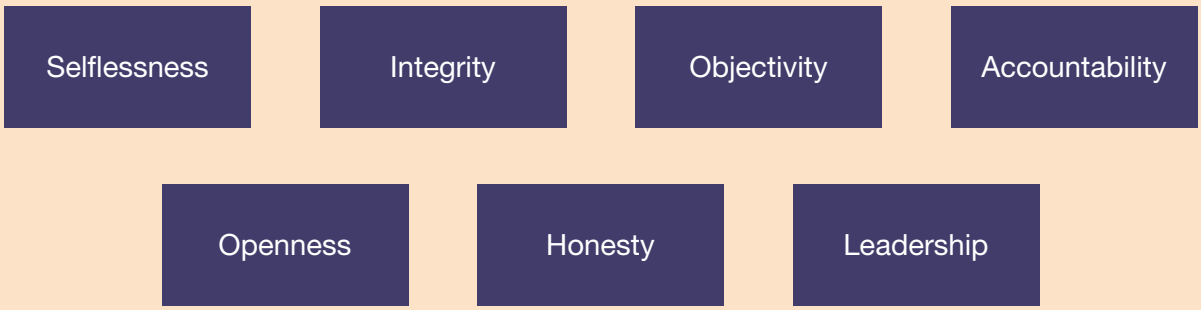
The Chair of the board of directors is also the Chair of the board of governors. The NHS foundation trust may decide that one governor should lead the board of governors where it is not considered appropriate for the Chair or another one of the non-executive directors to do so. One example may be a meeting discussing the appointment of the Chair. To prevent confusion with the deputy Chair, the governor chosen for this position should be called the Vice-Chair of the board of governors.

If governors decide that direct communication (not through the normal channel of the Chair) with Monitor is warranted, it should be facilitated through the Vice-Chair. Likewise, the Vice-Chair will be the primary contact for Monitor when communicating directly to the governors.

The Vice-Chair of the board of governors should be chosen by the board of governors.

The Nolan Principles

All holders of public office should adhere to the seven principles of public life, as defined by the Nolan Committee. The committee set the principles out for the benefit of all who serve the public in any way, and as such these principles apply to NHS foundation trust governors.



Further information on the Nolan Principles can be obtained here: **www.public-standards.org.uk**

Figure 3: The seven Nolan Principles

Trust secretary

NHS foundation trusts generally have a trust secretary (sometimes known as the board secretary). The trust secretary, an employee of the trust, often has a significant role to play in relation to the board of governors. For example, they can be expected to:

- ensure the procedures of the board of governors (as contained in the NHS foundation trust's constitution and/or elsewhere) are complied with;
- advise the board of governors (through the Chair) on all governance matters; and
- ensure good information flows within the NHS foundation trust, including to/from the board of governors.

Under the *Code of Governance*, the appointment and removal of the trust or board secretary will be a joint matter for the Chief Executive and Chair.

Membership secretary

Some NHS foundation trusts have also invested in the provision of a membership office or a membership secretary. The office will be responsible for:

- ensuring the flow of information between members and governors, for example sending out newsletters, coordinating member surveys and administering membership card schemes;
- coordinating, as appropriate, the elections for the board of governors;
- providing administrative support for governors to perform their duties; and
- maintaining the membership database and providing high level reports on membership.

Who regulates NHS foundation trusts?

Monitor is the Independent Regulator of NHS Foundation Trusts. It authorises and regulates NHS foundation trusts, making sure that they are legally constituted, well-led and financially robust.

Monitor receives and considers applications from bodies that seek NHS foundation trust status. If Monitor is satisfied that certain criteria are met, it authorises the relevant body as an NHS foundation trust. As part of this authorisation, the new NHS foundation trust is issued with "terms of Authorisation". These set out various conditions under which an NHS foundation trust is required to operate.

Monitor will look at an NHS foundation trust's activities to ensure that the NHS foundation trust complies with its terms of Authorisation. The Authorisation sets out the requirements placed on NHS foundation trusts and these requirements include, but are not limited to:

- putting, keeping in place and complying with arrangements for the purpose of monitoring and improving the quality of healthcare provided by and for that NHS foundation trust;
- delivering healthcare services to specified standards under agreed contracts with their commissioners;
- operating effectively, efficiently and economically as a going concern; and
- governing themselves in accordance with best practice, maintaining the organisation's capacity to deliver mandatory services.

Each NHS foundation trust's full terms of Authorisation are published on Monitor's website (www.monitor-nhsft.gov.uk). The essential terms of Authorisation are the same for every NHS foundation trust. The schedules to the terms of Authorisation contain bespoke requirements for each individual NHS foundation trust. Governors should familiarise themselves with their trust's terms of authorisation.

Monitor can use its statutory powers to intervene in the running of a failing NHS foundation trust, where the NHS foundation trust is in significant breach of its terms of Authorisation.

Intervention could include:

- requiring the NHS foundation trust, its directors or its governors to do, or not do, certain things; or
- removing or suspending any or all of the board of directors or the board of governors.

Whilst these powers may only be used where there is significant failure by an NHS foundation trust to comply with its terms of Authorisation, it is important that governors appreciate these powers exist.

As this guide explains, the board of governors has its own powers to intervene where the trust's performance is not acceptable. For example, the board of governors can also remove the Chair and/or the non-executive directors of an NHS foundation trust. The powers of the board of governors in this regard are described more fully in this guide.

Accountability structure for NHS foundation trusts

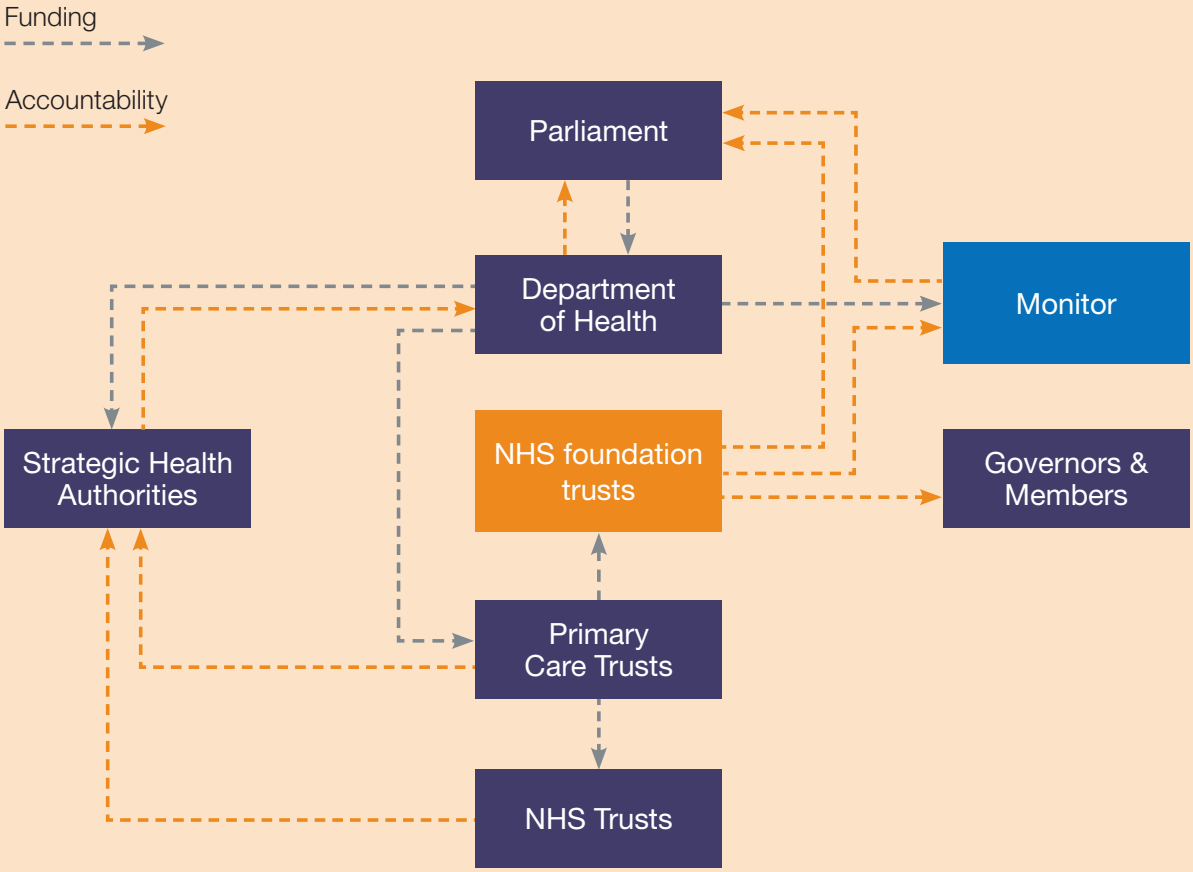


Figure 4: Who are NHS foundation trusts accountable to?

2 The role of a governor

The National Health Service Act 2006 gives the board of governors various statutory roles and responsibilities. As these roles and responsibilities are legal, they are of course mandatory.

This chapter sets out what, in formal terms, it means to be a governor of an NHS foundation trust.

Issues that we will look at in this chapter include:

- the statutory powers and duties of governors; and
- other requirements of governors, particularly those set out in the *Code of Governance*.

What are the statutory powers and duties of the board of governors?

The specific statutory powers and duties of the board of governors are to:

- appoint and, if appropriate, remove the Chair;
- appoint and, if appropriate, remove the other non-executive directors;
- decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other non-executive directors;
- approve the appointment of the Chief Executive;
- appoint and, if appropriate, remove the NHS foundation trust's auditor; and
- receive the NHS foundation trust's annual accounts, any report of the auditor on them and the annual report.

In addition, in preparing the NHS foundation trust's "forward plan", the board of directors must have regard to the views of the board of governors.

What does the Code of Governance say about governors?

In the *Code of Governance,* Monitor has provided best practice advice on what it means to be a governor. The key principles are as follows:

- every NHS foundation trust will have a board of governors which is responsible for representing the interests of NHS foundation trust members, and partner organisations in the local health economy in the governance of the NHS foundation trust;
- governors must act in the best interests of the NHS foundation trust and should adhere to its values and code of conduct;
- the board of governors should hold the board of directors collectively to account for the performance of the NHS foundation trust, including ensuring the board of directors acts so that the NHS foundation trust does not breach the terms of its Authorisation; and
- governors are responsible for regularly feeding back information about the NHS foundation trust, its vision and its performance to the constituencies and the stakeholder organisations that either elected them or appointed them.

Governors are encouraged to read the detailed terms of the *Code of Governance*, particularly in respect of their role within the NHS foundation trust.

Other duties

Governors are also heavily involved in many areas not covered by the legislation. Examples below illustrate some key areas where NHS foundation trusts have made great use of the skills and experience of their governors:

- holding constituency meetings to communicate with members;
- patient and service user liaison regarding patient experience;
- developing and reviewing the membership strategy, ensuring representation and engagement levels are maintained and increased as appropriate;
- working with hospital volunteers; and
- giving talks to interested stakeholders.

Organisations such as the Foundation Trust Network and the Foundation Trust Governors' Association may provide additional support and guidance in these areas.

3 The governors and the Chair

The Chair performs a crucial role within the NHS foundation trust and this chapter sets out some of the key issues that governors will need to consider in relation to the Chair.

Issues that we will look at in this chapter include:

- appointment of the Chair;
- terms and conditions; and
- removing the Chair

"Our Chair is appraised by an external party engaged by our nominations committee and the Board of Governors receives full and frank feedback"

What are the legal requirements?

Appointment and removal

The legislation says:

"It is for the board of governors at a general meeting to appoint or remove the Chairman…".

Therefore, it is for the board of governors as a whole (rather than, say, a committee or a working group) to appoint or remove the Chair.

In accordance with the legislation:

- *appointment* is by a majority of the governors attending the relevant general meeting; and
- *removal* requires the approval of three-quarters of the members of the board of governors, not just those who attend the meeting at which the Chair removal is to be discussed and determined.

Terms and conditions

The law says:

"It is for the board of governors at a general meeting to decide the remuneration and allowances, and the other terms and conditions of office, of the non-executive directors".

The Chair is one of the non-executive directors. Therefore, the board of governors is not only responsible for appointing the Chair, it also sets the terms of that appointment.

What other responsibilities are there?

Best practice (as set out in the *Code of Governance* and elsewhere) means that governors should perform specific additional tasks in relation to the Chair.

Annual performance appraisal

Conduct of performance appraisals and then reviewing the results will significantly assist the board of governors in performing its statutory duties, specifically when considering the potential re-appointment or removal of the Chair.

Therefore, the board of governors should take the lead on determining a process for the evaluation of the Chair. The senior independent director should lead the actual appraisal, although the Vice-Chair also has a significant role to play. The outcome of the evaluation should then be discussed and agreed with the board of governors.

The focus of the Chair's appraisal will be his/her performance as Chair of the board of directors and it should consider carefully the performance against pre-defined objectives that support the delivery of the trust's forward plan. This is largely because the legislation states that it is the Chair of the board of directors that chairs the board of governors (not the other way around). The primary aim of the Chair's work will be leading the directors.

This does not mean however that performance as the Chair of the board of governors is not a highly relevant part of the appraisal. The process should still be used as an opportunity to evaluate all relevant performance issues, including those relating to the governors.

"The Vice-Chair collates all the governors' views on the Chair's performance. This is discussed with the Senior Independent Director who then conducts the Chair's appraisal"

Appointing a deputy Chair

Where an NHS foundation trust's constitution makes provision for one, the governors will appoint a deputy Chair from the other non-executive directors.

Given that the nature of the role is to stand in for the Chair as required, this appointment should be made on the same basis as the appointment of the Chair. The process of appointment will be different though in that the appointed person will be selected from the existing non-executive directors. So, the board of governors will look at applicants from the current non-executive directors and choose from them.

The board of governors may, in the appropriate circumstances, decide that none of the candidates are appropriate for the role. If so, the board of governors should consider next steps in light of the NHS foundation trust's constitution and the need for a deputy Chair.

Section one
Appointment of the Chair

Governors will need to do a considerable amount of work to ensure that their NHS foundation trust has the right Chair in place.

General considerations

Further detail in relation to the role of a Chair is given in the *Code of Governance*. Governors should read this carefully before embarking on an appointment or re-appointment process. The Chair is one of the non-executive directors, therefore the later chapters on non-executive directors will also be relevant.

As with all appointments, the procedure for appointment or re-appointment must be formal, rigorous and transparent. The appointment must be based on merit and objective criteria, and the process should be described in the NHS foundation trust's annual report.

Triggers for action

The most common trigger for action will be the impending expiry of the existing Chair's term of appointment. The Chair may decide to seek re-appointment, in which case a decision will need to be made as to whether this is in the best interests of the NHS foundation trust and should happen.

If re-appointment is not sought, or it is decided that it is not appropriate to re-appoint (see later section on when re-appointment is sought), a new appointment will need to be made.

The governors also have the power to remove an existing Chair. If a Chair is removed in this way, again, a new appointment will need to be made.

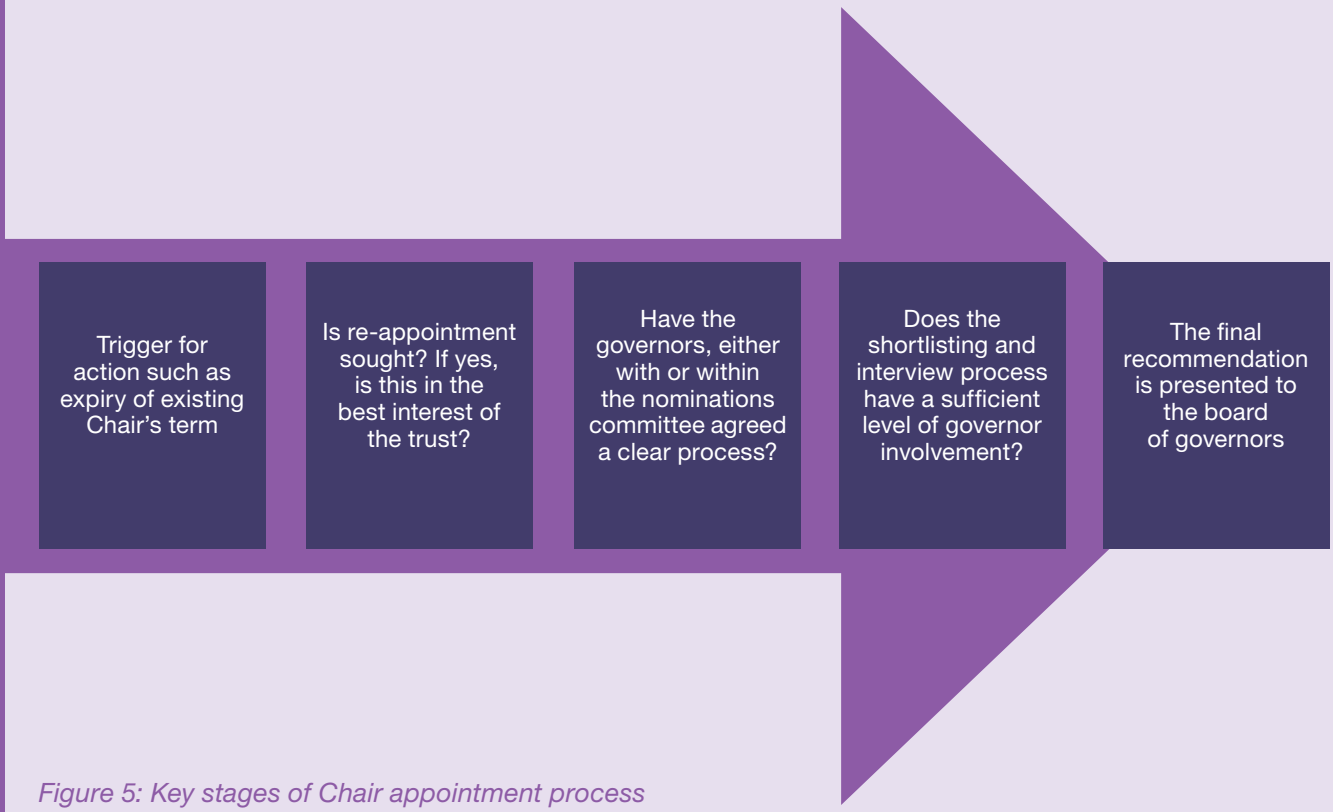


Figure 5: Key stages of Chair appointment process

Deciding on a process

The governors should agree with the nominations committee a clear process for the nomination of a new Chair and/or the re-appointment of an existing one. This process should include taking appropriate advice from within the NHS foundation trust such as from the trust's own HR department.

Where there is a specific nominations committee in respect of the Chair (and the other non-executive directors), then the board of governors should agree a process with that committee. Where there is only one nominations committee, the board of governors should appoint a working group, headed by the Vice-Chair of governors, to agree the process with the nominations committee and to report back to the board of governors.

In either case, the nominations committee should decide a job description and person specification defining the role and capabilities required, including an assessment of the time commitment expected for the role. Terms and conditions for the post should be proposed and, in normal circumstances, the post should be advertised. These matters should be agreed with the governors' working group where there is one.

The nominations committee, and where appropriate the governors' working group, should take into account the views of the board of directors (particularly the non-executive directors) on the process in general and the qualifications, skills and experience required for the position. In the same way and as appropriate, the nominations committee should consult other key stakeholders.

"Our trust has established a remuneration and terms of service sub-committee comprised of membership council members from both the public and staff constituencies. It is chaired by a Council member and receives advice from the Director of Personnel and commissions external advice when required"

Temporary appointments

When appropriate succession plans are in place, temporary arrangements are likely to occur only in exceptional circumstances. However, under such circumstances such as the Chair vacancy occurring at short notice, the governors may need to consider whether a temporary appointment needs to be made while the formal appointment process is being run. It may be that the deputy Chair is able to fulfil this role for the period required. The NHS foundation trust should again refer to its constitution in the first instance.

What if re-appointment is sought?

Where an existing Chair seeks re-appointment, the nominations committee, and where appropriate the governors' working group, should look at the existing candidate against the current job and person specification for their role at the NHS foundation trust. This job description should be reviewed on an ongoing basis by the nominations committee. In addition, the following matters should be considered.

Annual performance appraisals

The governors will need to consider the candidate's past performance at the NHS foundation trust, with particular regard to delivery of the role's objectives. The senior independent director should confirm to the governors whether, following formal performance evaluation, the performance of the Chair continues to be effective and to demonstrate commitment to the role.

It is the performance of the Chair as the Chair of the board of directors that is relevant here. The process should still be used as an opportunity to evaluate all relevant performance issues, including those relating to the governors, but it should not be the focus of consideration in relation to re-appointment.

Commitments

Any changes in the candidate's other significant commitments will be relevant. The new position in respect of commitments should be compared against the time commitment expected.

Refreshing the board of directors

Refreshment of the board provides an opportunity to reassess the skills, knowledge and experience required by the NHS foundation trust. It ensures the board of directors is exposed to new approaches, experiences and ways of working. It is healthy for the NHS foundation trust progressively to refresh the board of directors and this includes the Chair.

Terms

The re-appointment, if it happens, should be for a specified term of no longer than three years. Any candidate that has already served six years or more in the post should be rigorously reviewed and the process should take into account the need for progressive refreshing of the board of directors.

The *Code of Governance* states that "non-executive directors may serve longer than nine years" subject to annual re-appointment.

Once these processes have been undertaken, the re-appointment can be put to the full board of governors for a final decision *(see Figure 5 on page 18).*

What if a new appointment needs to be made?

If an existing Chair does not seek re-appointment on their current term expiring, their re-appointment is not approved or they are otherwise removed by either the board of governors or Monitor (where following Monitor's intervention, the board of governors is left to make an appointment), the NHS foundation trust will need to seek a new appointment since it is a statutory requirement for every NHS foundation trust to have a Chair.

A new appointment will mean, of course, that reliance on previous internal performance evaluations will not be possible. As a result, the appointment process will need particular care and scrutiny, and the board of governors must take the lead in ensuring that a well-defined and robust recruitment process is in place.

"In relation to the appointment of the Chair and new non-executive directors, following the short-listing exercise for all posts, our Nominations Committee organised stakeholder events, externally facilitated, to which all governors, directors and senior staff were invited, thus enabling maximum participation in the appointments process. The deliverable? A collective view of the areas to probe at each final interview"

Getting the right external advice and support

The board of governors is likely in many cases to decide that, in addition to the advice and support offered by the trust's own HR specialists, taking external advice on recruitment and executive search is appropriate. Typical reasons include where there is limited experience of senior recruitment within the governor group or where tough employment market conditions prevail.

When selecting external advisers, governors should consider matters including the potential advisers':

- previous experience of public sector recruitment;
- independence from the NHS foundation trust;
- track record of successful appointments;
- knowledge of the health sector and candidate research ability; and
- selected principles and processes, such as candidate assessment techniques.

Applications

The nominations committee with input, where appropriate, from a governors' working group and other key stakeholders may need to sift through the applications received for the post following its advertisement. The precise nature of this sifting will depend upon the circumstances in which the vacancy arose, the number of applications received and of candidates that are potentially appointable. Again, this may require external assistance, for example, from a recruitment consultant.

The nominations committee (taking into account the views of other non-executive directors and the governors' working party where there is one) should then put together a shortlist of no fewer than two candidates, with three or four candidates being the ideal numbers.

Interview

NHS foundation trusts should ensure there is majority governor representation on the interview panel.

Typically, the nominations committee, with participation, where appropriate, from the governors' working party, will interview the shortlisted candidates. An assessment should then be made as to which of the shortlisted candidates are appointable.

The appointable candidates are then put forward to the board of governors for the final decision on appointment.

How will the final decision be made?

Typically, a final report should be presented, incorporating the proposal for re-appointment or the presentation of new candidates, to the board of governors for consideration. The report should summarise the process followed by the nominations committee, including the selection criteria where appropriate.

The report should then describe how, and to what extent, the candidates meet the criteria for the role, their relative strengths and weaknesses and a recommendation on how the board of governors should proceed.

The board of governors must then make an appointment decision in accordance with its statutory obligations. As part of this, the board of governors will consider the issues set out in the report and any other factors it considers relevant. In particular, it should satisfy itself that all applicable law and guidance has been complied with, the process followed was legal and appropriate and that the proposed appointee has the right qualities to meet the job description for the role.

The board of governors should consult the board of directors (particularly the other non-executive directors) before the final decision is made.

Once the appointment decision is made, the senior independent director and the governors should set objectives for the coming year.

The full process followed should be described in the NHS foundation trust's annual report.

Section two

Terms and conditions of the Chair

A significant factor in attracting, retaining and motivating the Chair will be the terms and conditions, including pay, on offer to them. This section provides guidance on how governors should strike the right balance between motivating the right candidates and paying no more than is necessary.

What do the terms and conditions consist of?

The terms and conditions will form the Chair's appointment with the NHS foundation trust. They cover a variety of issues, the most important of which will include:

- the term that the Chair will serve;
- the responsibilities of the Chair;
- the remuneration and allowances that the Chair will receive. This will include any pay that the individual receives, but can also include non-taxable amounts;
- the location of work;
- the hours of work expected; and
- termination provisions including notice periods.

The most common point at which the terms and conditions for the Chair are set is on their appointment. However, the terms and conditions can be reviewed and altered throughout the Chair's term at the NHS foundation trust, provided the correct processes are followed.

How should the process work?

There should be a transparent procedure for deciding the terms and conditions of the Chair.

The terms and conditions in relation to a new appointment will be formulated by the nominations committee and agreed, where appropriate, with the governors' working group prior to the appointment being made. It must be remembered that the board of governors as a whole at a general meeting must make the final decision on the terms and conditions of the Chair, and it could choose to reject the proposals. With respect to existing appointments, again, it is the board of governors as a whole that makes the final decision on any revised terms and conditions.

New appointments – how do governors meet their responsibilities?

The nominations committee and, where appropriate, the governors' working group should agree the process for setting terms and conditions as part of the overall appointments process. This should be done after the job description has been finalised but before the post is advertised.

The factors that the nominations committee, (where appropriate) the governors' working group and, eventually, the board of governors will need to examine will vary depending on the position. However, central factors will be the:

- time commitment required by the role;
- responsibilities covered by the role; and
- terms and conditions available at similar NHS foundation trusts and other comparable organisations.

In addition to the advice and support available from the NHS foundation trust's own HR specialists, professional advice may need to be taken particularly on prevailing terms and conditions available. The board of governors may also want to look at guidance provided by other relevant bodies such as the Foundation Trust Network.

The nominations committee and, where appropriate, the governors' working group may also wish to consult with the NHS foundation trust's remuneration committee during this process. Although the remuneration committee is generally concerned with setting the pay of the executive directors and other employees, it will be able to provide useful input on matters such as the terms and conditions available at comparable organisations, trusted and experienced advisers and relevant performance indicators that may be applicable to both executive and non-executive directors.

When should terms and conditions be reviewed or changed?

It may be necessary to change the terms and conditions of the existing Chair. Changes to existing terms and conditions will need to be handled carefully and legal advice may need to be taken. This is because a poorly run process may lead to disputes and potential litigation.

A significant change in market conditions may mean existing terms and conditions should be reviewed. Regardless of significant change, governors should consult external professional advisers to market-test the pay levels and the other terms and conditions of the Chair at least once every three years.

There may be a marked change in the range of the Chair's responsibilities or in their time commitment to the role. The governors should take the lead in conducting a review of the Chair's terms and conditions in light of any such change. Where there is to be a significant change in those terms and conditions, particularly with regards to pay, external professional advice (including legal advice) should be sought before any changes are made.

How will the final decision be made?

Any new or changed set of terms and conditions of the Chair will require a decision by the board of governors at a general meeting. This meeting should be informed by a report (including recommendations) of either the nominations committee or, where appropriate, the governor's working group.

In relation to a new appointment, the revised terms and conditions should form part of the appointment decision.

There should be full transparency in relation to the terms and conditions in the NHS foundation trust's annual report.

Section three
Removing the Chair

Removing the Chair will be a very serious step and the board of governors must follow a rigorous and transparent process in order to take it.

What are the possible reasons for removal?

Governors will appreciate that removing the Chair is only likely to be appropriate in very limited circumstances and will depend on the particular nature of those circumstances. However, governors must clearly understand the reasons which may lead to a removal decision before embarking on the removal process.

Common circumstances where removal should be considered include, but are not limited to:

- alleged gross misconduct on the part of the Chair;
- the Chair losing the confidence of the board of directors or governors; or
- the NHS foundation trust being in serious breach of its terms of authorisation and the Chair is judged as being responsible for the breach.

What is the process for removal?

The board of governors should only exercise its power to remove the Chair as a last resort.

The removal should not take place unless the governors and other non-executive directors have had the opportunity to put forward their views on the basis of the available evidence. A suggested process is set out in *Figure 6.*

Vote of no confidence

The first step is likely to be a vote of no confidence in the Chair by a majority of the board of governors. This will not in itself result in the removal of the Chair, but will start the formal process for the removal.

Before the confidence vote, the board of governors should discuss the matter with the other non-executive directors, and in particular the senior independent director. However, the decision on whether to hold a confidence vote is one for the board of governors. If the vote is carried by a majority of governors, the Vice-Chair should directly inform Monitor, via the NHS foundation trust's relationship manager.

Investigation, advice and consultation

The nominations committee, with appropriate representatives from the board of governors, should then investigate the matter, including any allegations made against the Chair. The trust may decide that an independent investigation is warranted under certain circumstances and this should be determined by the trust alone.

This investigation should include consideration of the views of key personnel within the NHS foundation trust, including the non-executive directors. Additional weight should be given to the views of the independent non-executive directors and particularly the senior independent director.

Legal advice on the legality of any removal and the process for it should be sought throughout.

Suspension

The board of governors may wish to consider whether it can and should suspend the Chair while the process is followed. Legal advice will need to be sought on whether there is a power to suspend, whether suspension is appropriate and the terms (including the length) of any suspension.

Report

A senior representative of the nominations committee should then present the findings of the investigation and consultation to the board of governors.

Throughout the process, the Chair must be given an adequate opportunity to respond to the allegations made against them.

Figure 6: Overview of removal process

How will the final decision be made?

If the board of governors is content that a full and proper process has been followed, it should call for a full meeting of the board of governors and vote on the matter. If it is in any doubt about the process, it should seek clarification and remedy any deficiencies before voting.

Removal of the Chair requires the approval of three-quarters of the members of the whole board of governors.

Process when Monitor removes a chair

There may be circumstances when, following a significant breach of an NHS foundation trust's terms of authorisation, Monitor exercises its statutory powers to suspend or remove a chair. Under such circumstances, Monitor's statutory powers take precedent over the powers that may be exercised by the board of governors.

What are the next steps following removal?

In the event that removal takes place, a new appointment will need to be made.

A description of the reasons for, and process of, removal will need to be set out in the NHS foundation trust's next annual report.

4 The governors and the non-executive directors

The non-executive directors provide independence and balance to the executive element of the board of directors.

This chapter sets out some of the key issues that governors will need to consider in relation to the non-executive directors.

Issues that we will look at in this chapter include:

- appointment of a non-executive director;
- terms and conditions; and
- removing non-executive directors.

"The trust established a committee formed of governors and chaired by the Vice-Chair. This committee advises the board of governors on progress with all non-executive director issues such as recruitment, retention, appraisal and terms of service"

What are the legal requirements?

The legislation requires that an NHS foundation trust has non-executive directors. The number of non-executive directors will be set out in the NHS foundation trust's constitution.

Appointment and removal

The legislation says:

"It is for the board of governors at a general meeting to appoint or remove the…non-executive directors".

Therefore, it is for the board of governors as a whole (rather than, say, a committee or a working group) to appoint or remove the non-executive directors.

In accordance with the legislation:

- *appointment* is by a majority of the governors attending the relevant meeting; and
- *removal* requires the approval of three-quarters of the members of the board of governors, not just those who attend the meeting.

Terms and conditions

The legislation says:

"It is for the board of governors at a general meeting to decide the remuneration and allowances, and the other terms and conditions of office, of the non-executive directors".

Therefore, the board of governors is not only responsible for appointing the non-executive directors, it also sets the terms of those appointments.

What other responsibilities are there?

Best practice (as set out in the *Code of Governance* and elsewhere) means that governors should perform specific additional tasks in relation to the non-executive directors.

Annual performance appraisal

Conduct of performance appraisals and then reviewing the results will significantly assist the board of governors in performing its statutory duties in respect of the potential re-appointment or removal of the non-executive directors. The board of governors should take the lead on agreeing a process for the evaluation of the non-executives which should consider carefully the performance against pre-defined objectives that support the delivery of the trust's forward plan.

The actual appraisals of the non-executive directors will be led by the Chair. The outcome of the evaluations should then be agreed by the governors.

Senior independent director

The appointment of the senior independent director is made by the board of directors, in consultation with the board of governors. Further detail in relation to the senior independent director can be found in the *Code of Governance.*

Section one
Appointing a non-executive director

As with the Chair, the governors will need to do a considerable amount of work to ensure that the other non-executive directors are fit and proper persons for the foundation trust.

General considerations

Further detail in relation to the role of a non-executive director is given in the *Code of Governance*. Governors should read this carefully before embarking on an appointment or re-appointment process.

As with all appointments, the procedure for appointment or re-appointment must be formal, rigorous and transparent. The appointment must be based on merit and objective criteria, and the process should be described in the NHS foundation trust's annual report.

As part of the process, the governors should consider the relevant aspects of the NHS foundation trust's constitution and the *Code of Governance*, such as:

- the requirements of the NHS foundation trust's constitution in respect of the number of non-executive directors;
- the independence of non-executive directors; and
- the balance of executive and non-executive (and in particular independent non-executive) directors on the board of directors.

Triggers for action

The most common trigger for action will be the impending expiry of an existing non-executive director's term. The non-executive director may decide to seek re-appointment, in which case a decision will need to be made as to whether this is in the best interests of the NHS foundation trust and should happen. If re-appointment is not sought, or it is decided that it is not appropriate to re-appoint, a new appointment will need to be made.

Governors also have the power to remove an existing non-executive director. If a non-executive director is removed in this way, again, a new appointment may need to be made.

Deciding on a process

The governors should agree with the nominations committee a clear process for the nomination of a new appointment or the re-appointment of an existing one. This process should include taking appropriate advice from within the NHS foundation trust such as from the trust's own HR department.

Where there is a specific nominations committee in respect of the non-executive directors, then the board of governors should agree a process with that committee. Where there is only one nominations committee, the board of governors should appoint a working group, headed by the Vice-Chair of governors, to agree the process with the nominations committee and to report back to the board of governors.

In either case, the nominations committee should decide a job description and person specification defining the role and capabilities required, including an assessment of the time commitment expected for the role. Terms and conditions for the post should be proposed and, if appropriate, the post should be advertised. These matters should be agreed with the governors' working group where there is one.

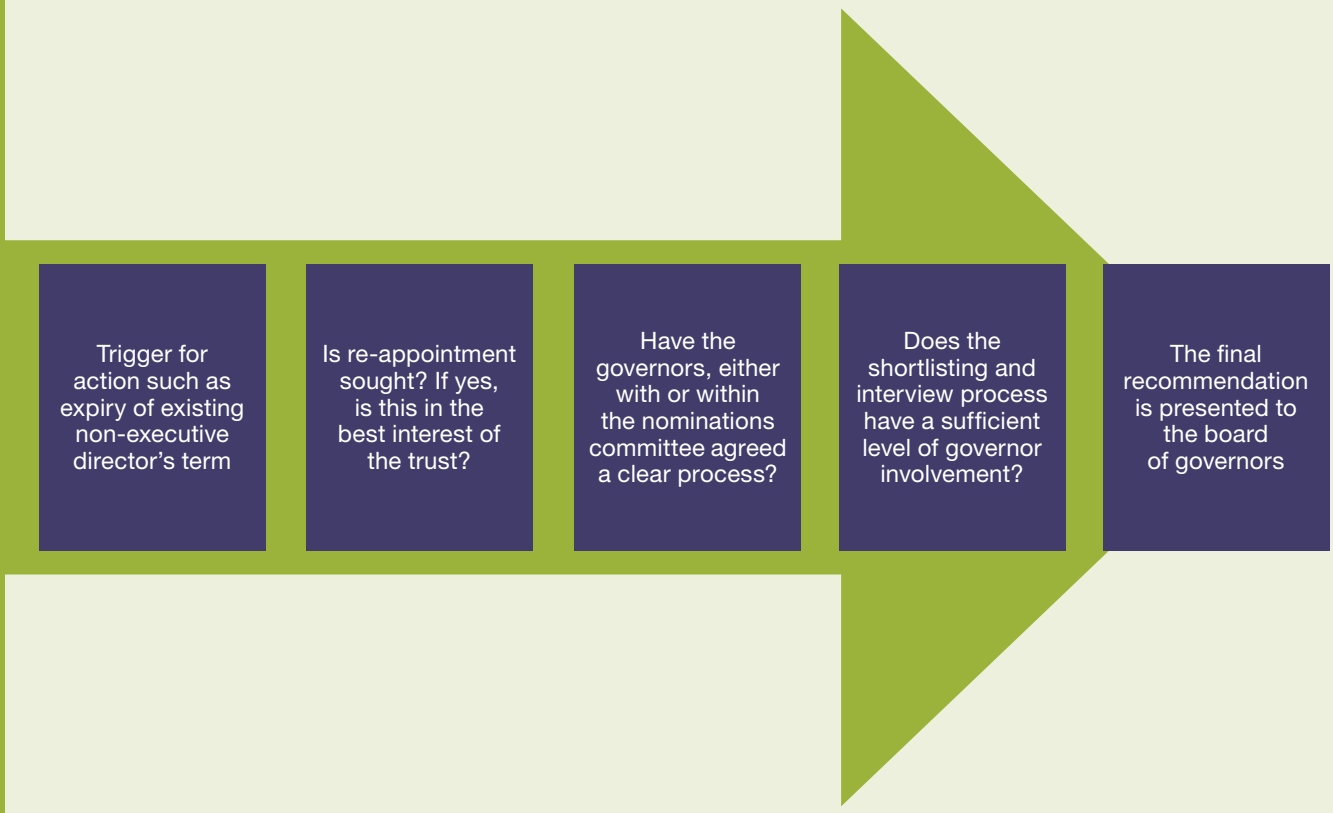


Figure 7: Key stages of non-executive appointment process

"Our governors now receive summarised 360-degree feedback for all executive and non-executive directors. How else can we be sure they are doing the job we hired them to do?"

The nominations committee, and where appropriate the governors' working group, should take into account the views of the board of directors on the process in general and the qualifications, skills and experience required for the position. For example, if the directors advise that the board of directors is lacking specific professional experience (e.g. legal, clinical or accountancy), this should be fed into the recruitment process. In the same way and as appropriate, the nominations committee should consult other key stakeholders.

Temporary appointments

When appropriate succession plans are in place, temporary arrangements are likely to occur only in exceptional circumstances. However, under such circumstances such as the vacancy occurring at short notice, the governors may need to consider whether a temporary appointment needs to be made while the formal appointment process is being run.

What if re-appointment is sought?

Where an existing non-executive director seeks re-appointment, the nominations committee and, where appropriate, the governors' working group should look at the existing candidate against the current job and person specification for their role at the NHS foundation trust. This job description should be reviewed on an ongoing basis by the nominations committee. In addition, the following matters may be relevant.

Annual performance appraisals

In relation to non-executive directors, consideration should be given to the candidate's past performance at the NHS foundation trust. The Chair should confirm to the governors that, following formal performance evaluation, the performance of the individual non-executive director proposed for re-appointment continues to be effective and demonstrates commitment to the role.

Independence

Any changes in the independence (as described in the *Code of Governance*) of the non-executive director should be taken into account.

Commitments

Any changes in the candidate's other significant commitments will be relevant. The new position in respect of commitments should be compared against the time commitment expected.

Refreshing the board of directors

Refreshment of the board of directors provides an opportunity to reassess the skills, knowledge and experience required by the NHS foundation trust. It ensures the board of directors is exposed to new approaches, experiences and ways of working. It is healthy for the NHS foundation trust to refresh the board of directors and this includes the non-executive directors.

Terms

The re-appointment, if it happens, should be for a specified term of no longer than three years. Any candidate that has served six years or more should be rigorously reviewed and the process should take into account the need for progressive refreshing of the board of directors.

A non-executive director may serve longer than nine years, subject to annual re-appointment. In the case of a non-executive director, the length of service is relevant to the determination of his or her independence in accordance with the *Code of Governance.*

Once these processes have been undertaken, the re-appointment can be put to the board of governors for a final decision (*see Figure 7*).

"We expected dissent and resistance – recruiting at this level is a significant challenge – but by using our members' skills combined with independent advice when required, the process was challenging but even-handed"

What if a new appointment needs to be made?

If a non-executive director does not seek re-appointment on their current term expiring, their re-appointment is not approved or they are otherwise removed by either the board of governors or Monitor (where, following Monitor's intervention, the board of governors is left to make an appointment), the NHS foundation trust may need to seek a new appointment.

Whether or not a new appointment is required will depend on the NHS foundation trust's constitutional requirements and the needs of the NHS foundation trust. This issue should be discussed with the board of directors and, in particular, with the Chair.

A new appointment will mean, of course, that reliance on previous internal performance evaluations will not be possible. As a result, the appointment process will need particular scrutiny and the board of governors should take the lead in ensuring that a well-defined and robust recruitment process is in place. In many cases, it will be appropriate to take external recruitment advice.

Getting the right external advice

The board of governors is likely in many cases to decide that, in addition to the advice and support offered by the trust's own HR specialists, taking external advice is appropriate. Typical reasons include where there is limited experience of senior recruitment within the governor group or where tough employment market conditions prevail.

When selecting external advisers, governors should consider matters including the potential advisers':

- previous experience of public sector recruitment;
- independence from the NHS foundation trust;
- track record of successful appointments;
- knowledge of the health sector and candidate research ability; and
- selected principles and processes, such as candidate assessment techniques.

Applications

The nominations committee with input, where appropriate, from the governors' working group will need to sift through the applications received for the post. The precise nature of this sifting will depend upon the circumstances in which the vacancy arose, the number of applications received and of potentially appointable candidates. Again, this may require external assistance, for example, from a recruitment consultant.

The nominations committee (with input from the other non-executive directors and the governors' working party where there is one) should then put together a shortlist of no fewer than two candidates, with three or four candidates being the ideal number.

Interview

NHS foundation trusts should ensure there is majority governor representation on the interview panel. Typically, the nominations committee, with participation, where appropriate, from the governors' working party, will interview the shortlisted candidates. An assessment should then be made as to which of the shortlisted candidates are appointable.

The appointable candidates are then put forward to the board of governors for the final decision on appointment.

How will the final decision be made?

Typically, a final report should be presented, incorporating the proposal for re-appointment or the presentation of new candidates, to the board of governors for consideration. The report should summarise the process followed by the nominations committee, including the selection criteria where appropriate.

The report should then describe how, and to what extent, the candidates meet the criteria for the role, their relative strengths and weaknesses and a recommendation on how the board of governors should proceed.

The board of governors must then make an appointment decision in accordance with its statutory obligations. As part of this, the board of governors will consider the issues set out in the report and any other factors it considers relevant. In particular, it should satisfy itself that all applicable law and guidance has been complied with, the process followed was legal and appropriate and that the proposed appointee has the right qualities to meet the job description for the role.

The board of governors should consult the board of directors (particularly the other non-executive directors) before the final decision is made.

Once the appointment decision is made, the Chair and the governors should set objectives for the coming year.

The full process followed should be described in the NHS foundation trust's annual report.

Section two

Terms and conditions of the non-executive directors

A significant factor in attracting, retaining and motivating non-executive directors will be the terms and conditions, including the levels of pay, on offer to them. This section provides guidance on how governors should strike the right balance.

What do the terms and conditions consist of?

The terms and conditions will form the non-executive director's appointment with the NHS foundation trust. They will cover a variety of issues, the most important of which will include:

- the term that the non-executive director will serve;
- the responsibilities of the non-executive director;
- the remuneration and allowances that the non-executive director will receive. This will include any pay that the individual receives, but can also include non-taxable amounts;
- the location of work;
- the hours of work expected; and
- termination provisions including notice periods.

The most common point at which the terms and conditions of a particular non-executive director are set is on their appointment. However, the terms and conditions can be reviewed and altered throughout the non-executive's term at the NHS foundation trust, provided the correct processes are followed.

How should the process work?

There should be a transparent procedure for deciding the terms and conditions of individual non-executive directors.

The terms and conditions in relation to a new appointment will be set by the nominations committee and agreed, where appropriate, with the governors' working group prior to the appointment being made. However, it must be remembered that the board of governors as a whole will be making the ultimate decision on the relevant appointment's terms and conditions at a general meeting and it could choose to reject the proposals.

With respect to existing appointments, again, it is the board of governors as a whole that makes the final decision on any revised terms and conditions.

New appointments – how do governors meet their responsibilities?

Governors will be aware that all money paid to non-executive directors is taxpayers' money – a foundation trust should ensure that value for public money is obtained.

The nominations committee and, where appropriate, the governors' working group should agree the process for setting terms and conditions as part of the overall appointments process. This should be done after the job description has been finalised but before the post is advertised.

The factors that the nominations committee, (where appropriate) the governors' working group and, eventually, the board of governors will need to examine will vary depending on the position. However, central factors will be:

- the time commitment required by the role;
- the responsibilities covered by the role; and
- the terms and conditions available at similar NHS foundation trusts and other comparable organisations.

In addition to the advice and support available from the NHS foundation trust's own HR specialists, professional advice may need to be taken, particularly on prevailing terms and conditions. The board of governors may also want to look at guidance provided by other relevant bodies such as the Foundation Trust Network.

The nominations committee and, where appropriate, the governors' working group may also wish to consult with the NHS foundation trust's remuneration committee during this process.

Although the remuneration committee is generally concerned with setting the remuneration of the executive directors, it will be able to provide useful input on matters such as the terms and conditions available at comparable organisations, trusted and experienced advisers and relevant performance indicators that may be applicable to both executive and non-executive directors.

When should terms and conditions be reviewed or changed?

It may be necessary to change the terms and conditions of an existing non-executive director, or a group of non-executive directors. Changes to existing terms and conditions will need to be handled carefully and legal advice may need to be taken. A poorly run process may lead to disputes and potential litigation.

A significant change in market conditions may mean existing terms and conditions should be reviewed. Regardless of significant change, governors should consult external professional advisers to market-test the pay levels and the other terms and conditions of the non-executive directors at least once every three years.

"Our committee exists to ensure that NEDs' terms of appointment are clear and attractive in order to ensure that high calibre non-executive directors can be recruited and, as importantly, retained"

In terms of individuals, there may be a marked change in an individual's responsibilities or their time commitment to the role. If so, governors should take the lead in conducting a review of the individual's terms and conditions. Where there is to be a significant change in the terms and conditions applicable to a specific individual, particularly with regards to pay, external professional advice (including legal advice) should be sought before any changes are made.

How will the final decision be made?

Any new or changed set of terms and conditions of the non-executive directors will require a decision by the board of governors at a general meeting. This meeting should be informed by a report (including recommendations) of either the nominations committee or where appropriate, the governors' working group.

In relation to a new appointment, the revised terms and conditions should form part of the appointment decision.

There should be full transparency in relation to the terms and conditions in the NHS foundation trust's annual report.

Section three
Removing non-executive directors

What are the possible reasons for removal?

Governors will appreciate that the removal of a non-executive director is only likely to be appropriate in limited circumstances.

Possible reasons for the removal (for example, alleged gross misconduct or a request from the board of directors for the removal of a particular non-executive director) will depend on the particular circumstances. However, the governors must clearly understand the potential reasons which may lead to a removal decision before embarking on a removal process.

What is the process for removal?

The board of governors should only exercise its power to remove a non-executive director as a last resort.

The removal should not take place unless the governors and the other non-executive directors (in particular the Chair and senior independent non-executive director if he or she is not the subject of the process) have had the opportunity to put forward their views on the basis of the available evidence.

"As a standard process, our committee meets three times a year; once to review salary; once to touch base on the NED appraisal process; and once to get feedback on appraisals and terms of office"

A suggested process is set out below.

Vote of no confidence

The first step is likely to be a vote of no confidence in the individual by a majority of the board of governors. This will not in itself result in the removal of that individual, but will start the formal process for the removal.

Before the confidence vote, the board of governors should discuss the matter with the other non-executive directors, and in particular the Chair and the senior independent director. However, the decision on whether to hold a confidence vote is one for the board of governors.

Investigation, advice and consultation

The nominations committee, with appropriate representatives from the board of governors, should then investigate the matter, including any allegations made against the individual. The trust may decide that an independent investigation is warranted under certain circumstances and this should be determined by the trust alone. This investigation should include consideration of the views of key personnel within the NHS foundation trust, including the Chair. Additional weight should be given to the views of the independent non-executive directors and particularly the senior independent director (where he or she is not the individual under scrutiny).

Legal advice on the legality of any removal and the process for it should be sought throughout.

Suspension

The board of governors may wish to consider whether it can and should suspend the relevant non-executive director while the process is followed. Legal advice will need to be sought on whether there is a power to suspend, whether suspension is appropriate and the terms (including the length) of any suspension.

Report

A senior representative of the nominations committee should then present the findings of the investigation and consultation to the board of governors. The board of governors must ensure all individuals are given an adequate opportunity to respond to any allegations made.

How will the final decision be made?

If the board of governors is content that a full and proper process has been followed, it should vote on the matter. If it is in any doubt about the process, it should seek clarification and/or remedy any deficiencies before voting.

Removal of a non-executive director requires the approval of three-quarters of the members of the whole board of governors.

Process when Monitor removes a non-executive director

There may be circumstances when, following a significant breach of a foundation trust's terms of authorisation, Monitor exercises its statutory powers to suspend or remove a non-executive director. Under such circumstances, Monitor's statutory powers take precedent over the powers that may be exercised by the board of governors.

What are the next steps following removal?

In the event that removal takes place, the NHS foundation trust will need to consider whether or not a new appointment needs to be made to replace the removed director.

A description of the reasons for and process of removal will need to be set out in the NHS foundation trust's next annual report.

5 Approving the appointment of the Chief Executive

This chapter looks at the role of governors in relation to the appointment of the chief executive of an NHS foundation trust.

Issues that we will look at in this chapter include:

- factors to consider when making a decision to approve; and
- what to do if approval is not given.

"Our board of governors approved the appointment of the Chief Executive – and it went very well. One of the key reasons behind the success of the process was the involvement of a governor, as a key member of the selection panel and therefore someone able to provide full and frank information regarding the reasons for appointment"

What are the legal requirements?

The legislation says: "The appointment of a Chief Executive requires the approval of the board of governors".

Note that this does not mean that the board of governors **appoints** the Chief Executive.

What does "approval" mean?

It is for the non-executive directors (including the Chair) to appoint or remove the Chief Executive. However, the board of governors has to approve that decision and, therefore, can veto the appointment of a particular Chief Executive.

The *Code of Governance* says that approval by the board of governors of the appointment of a Chief Executive should be a subject of the first general meeting of that board following the appointment by a committee of the Chair and non-executive directors.

The *Code of Governance* goes on to say that re-appointment by the non-executive directors followed by re-approval by the board of governors thereafter should be made at intervals of no more than five years.

The process would be for non-executive directors to put forward a candidate for appointment and for the board of governors to decide whether to approve that appointment. The board of governors may decide not to approve the candidate. It is envisaged that such a situation will be rare and sound (including legally sound) reasons are required for this.

What factors should the governors look at before making a decision?

This will depend on the circumstances. However, there are three main areas for the board of governors to consider.

Law and guidance

Governors should satisfy themselves that non-executive directors have complied with the NHS foundation trust's constitution and other relevant guidance such as the *Code of Governance* when appointing a Chief Executive.

Process

Governors should consider the appointment process followed by non-executive directors. They must ensure they are content with the various stages of the appointment process such as use of advertisements, the criteria for selection and how selection was carried out. Involvement of governors in the selection process will result in the board of governors having a clearer understanding of how the process worked.

"Our governors are now involved in other executive appointments – candidates present to the board of governors and the governors' feedback is included in the formal interviews"

Proposed candidate

Governors should be content that the appointment process has identified a candidate with sufficient experience to fulfil all essential aspects of the job description.

The board of governors should expect a full report from the non-executive directors or appropriate committee drawn from their number regarding the above matters. Nonetheless, the board of governors must recognise that the primary appointment obligation is on the non-executive directors in accordance with their own legal obligations in this regard. As such, the board of governors should not withhold approval lightly.

If approval is withheld, the board of governors must set out their reasons to the Chair and the other non-executive directors.

Figure 8: Key elements of the report prepared by the non-executive directors

"We have never refused to appoint but that is because as governors we are involved throughout the appointment process"

What if the board of governors does not give approval?

It is incumbent on both the non-executive directors and the board of governors to work together to break any deadlock.

It will be open to the non-executive directors to put forward again the same candidate up for approval by the board of governors. This may be with further assurances in relation to any concerns that the board of governors previously expressed in refusing approval.

Alternatively, the non-executive directors may decide to seek a new candidate for appointment and approval by the board of governors.

The process, the decision and the reasons for that decision should be set out in the NHS foundation trust's annual report, whatever the outcome.

6 The governors and the NHS foundation trust's auditor

The auditor of an NHS foundation trust has important duties in relation to the foundation trust's annual accounts.

This chapter sets out the governors' role in relation to the auditor.

Note that this chapter relates to the NHS foundation trust's external, not internal, auditor.

Issues that we will look at in this chapter include:

- what the auditor does;
- who the auditor can be; and
- appointing and removing the auditor.

What are the legal requirements?

Governors will need to undertake a considerable amount of work to ensure that the right auditor is in place and that an auditor will perform effectively.

The legislation says that the NHS foundation trust must have an auditor.

The board of governors' role is set out as follows:

"It is for the board of governors to appoint or remove the auditor at a general meeting of the board".

Therefore, the board of governors as a whole (rather than, say, a committee or a working group) appoints or removes the auditor.

Audit committee

The audit committee is responsible for monitoring and reviewing matters such as the integrity of financial statements of the NHS foundation trust, the NHS foundation trust's internal financial controls and the internal audit function.

The audit committee must consist of non-executive directors. *The Code of Governance* states that the committee should have at least three independent non-executive directors and that at least one member of the audit committee should have recent and relevant financial experience.

Governors are not members of the audit committee. However, under the *Code of Governance*, the audit committee should report to the board of governors identifying any matters where it considers action or improvement is needed and making recommendations on the steps to be taken.

What other responsibilities are there?

In order to support the underlying statutory duty, the *Code of Governance* states that the audit committee should report to the board of governors, identifying any matters where it considers that action or improvement is needed.

The report should also make recommendations as to the steps to be taken. The governors will need to consider such reports closely, particularly with regards to holding directors to account for trust performance.

The governors will also want to look at *The Audit Code for NHS Foundation Trusts* and, in particular, the criteria for auditors set out in the *Audit Code*.

What does the auditor do?

The auditor has statutory duties in auditing the accounts of an NHS foundation trust. These involve ensuring that:

- the accounts are prepared in accordance with all relevant directions set by Monitor and any other statutory provisions;
- proper practices have been observed in the compilation of the accounts; and
- the NHS foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Further details on the auditor's role are set out in Monitor's document, the *Audit Code*.

"Our governors undertook a detailed review of the selection process from advertising through to devising the interview structure"

Who can be the auditor?

On authorisation as an NHS foundation trust, the auditor appointed by the Audit Commission to the predecessor NHS trust will continue to be appointed until the board of governors has had an opportunity to discuss the matter.

An engagement letter must therefore be agreed between the NHS foundation trust and the incumbent auditors for that interim period so that there is not a period during which the NHS foundation trust has no auditor in place. Thereafter, the NHS foundation trust is free to appoint which ever auditor it considers to be the most appropriate.

The auditor can either be an individual, from a firm of auditors or an officer of the Audit Commission. However, the auditor (or in the case of a firm, each of its members) must be a member of one of a list of specified professional bodies set out in legislation.

In addition, the *Audit Code* includes particular criteria that the auditor must be able to demonstrate that it meets, not only on appointment but throughout its term as auditor. The auditor must:

- have an established and demonstrable standing within the healthcare sector and be able to show a high level of experience and expertise. The work is of a specialised nature, and so general audit experience is not sufficient;
- comply with the *Audit Code*; and
- subject the audit to internal quality control procedures that are sufficiently robust to monitor the compliance of the audit work with the *Audit Code*.

If the auditor fails to meet, or has cause to believe that it will not be able to comply with, the criteria set out in the *Audit Code* at any point during its appointment, the auditor must resign.

Consideration should be given to whether the team at the auditor's firm should be changed. A team that has been in place for too long may no longer be able to perform its role to the requisite standard of independence from the NHS foundation trust. As a consequence, it is good practice for the team to be altered every two to three years, even if the firm remains the same.

Annual process

The audit committee should make a report to the board of governors in relation to the auditor.

Such a report should be made after the completion of the annual audit and should assess the auditors' work and fees to ensure that the work is of a sufficiently high standard and the fees are reasonable.

The audit committee must make a recommendation to the board of governors with respect to the retention of the auditor. The board of governors should then consider whether it may be appropriate to remove the auditor.

"We used our 'skills and experience' audit to determine the most appropriate governors to fulfil this important role"

Section one
Appointing the auditor

What is the trigger for action?

The most common trigger for action will be the impending expiry of the existing auditor's contract term. With this, a new appointment process will need to be undertaken, whether or not the existing auditor is seeking re-appointment.

Governors also have the power to remove an existing auditor and, in certain situations, an auditor can or should resign. If either event occurs, then a new appointment will need to be made.

What are the over-arching principles?

As with all appointments, the procedure for appointment (or re-appointment) must be formal, rigorous and transparent. The appointment must be based on merit and objective criteria and the process should be described in the NHS foundation trust's annual report.

Deciding on a process

The board of governors should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing or removing auditors.

Initial steps

The audit committee will drive the process in the first instance. However, the final decision on any appointment rests with the board of governors.

The audit committee should agree with the board of governors a clear process for the nomination of a new auditor or the re-appointment of an existing one. The board of governors should set up an audit working group made up of governors to liaise with the audit committee.

The audit committee should then prepare a specification defining the role and capabilities required. This should be agreed with the governors' audit working group.

Procurement process

Once the audit committee (in consultation with the board of governors or the working group) has decided on the qualifications, skills and experience required of the auditor, it should run a formal procurement process to obtain the best candidate in the most fair and transparent manner possible.

The exact form of the procurement process will vary depending on the NHS foundation trust. It will be in accordance with the NHS foundation trust's own procurement rules and must be within procurement law. Procurement law is complex and the audit committee and the governors' audit working group should seek legal advice before embarking on a new procurement process.

Even if the existing auditor is seeking re-appointment, they must be treated in the same way as all other candidates for the role. The same criteria should be applied to all those that express an interest in becoming the auditor of the NHS foundation trust.

Shortlist

The audit committee should decide on a shortlist of at least two appointable candidates. This shortlist should be considered in conjunction with the governors' audit working group.

Re-appointment

Provided the correct process is followed and the appropriate criteria are met, the existing auditor may be on the final shortlist of candidates.

Presentation by the audit committee

The audit committee and the governors' audit working group should present to the board of governors, setting out:

- the procurement process that it has followed;
- the results of the procurement process; and
- recommendations.

The recommendations should include a full description of the shortlisted candidates and an assessment of the relative strengths and weaknesses of those candidates.

In addition, as part of its recommendations, there should be proposals in respect of the terms of engagement of the external auditor.

How will the final decision be made?

The board of governors should then make a decision in accordance with its statutory obligations.

If the board of governors makes an appointment, the terms of engagement of the auditor will need to be approved by the audit committee. In particular, the board of governors and the audit committee should consider for how long the appointment should last. Best practice is to appoint an auditor for a period which allows it to develop a strong understanding of the NHS foundation trust. The norm will be a three to five year appointment.

In the event that the board of governors does not feel able to make an appointment, for example because it is not willing to accept the recommendations made to it or it believes that the procurement process was flawed or otherwise, then the matter will revert back for further consideration and action by the audit committee and the governors' audit working group. The NHS foundation trust must have an auditor. As such, the speed of the process must reflect this statutory requirement and therefore the timelines of the particular appointment process should be adhered to.

In all cases, the full process must be set out in the NHS foundation trust's annual report. In particular, if the board of governors does not accept the audit committee's recommendation, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and the reasons why the board of governors took a different position.

Section two
Removing the auditor

Removing the auditor will be a very serious step and the board of governors must follow a rigorous and transparent process in order to take it.

What are the possible reasons for removal?

The board of governors will recognise that removal of the auditor is only likely to be appropriate in limited circumstances. This is particularly as the auditor has a significant independent role within the NHS foundation trust.

Possible reasons for the removal will depend on the circumstances. A key point the governors will need to look at is whether the auditor continues to meet the criteria set out in the *Audit Code*. If the auditor does not meet these criteria, there may be grounds for the removal of the auditor.

The governors must, of course, clearly understand the reasons for potential removal before embarking on the removal process.

What is the process?

The board of governors should only exercise its power to remove the auditor after exhausting all other means of resolving any dispute. If it is not possible to resolve the issue, then a suggested process is set out below.

Proposal

The first step should be a proposal to consider removal by the board of governors. This will not in itself result in the removal of the auditor, but will start the formal process of removal.

Investigation, advice and consultation

The audit committee should investigate the matter, including, where appropriate, any allegations made against the auditor.

The investigation should include consideration of the views of key personnel within the NHS foundation trust, including the NHS foundation trust's finance director and his/her staff.

Legal advice on the legality of any removal and the process for it should be sought throughout.

Report

The audit committee should present the findings of the investigation and consultation to the board of governors. The board of governors must ensure that auditors are given adequate opportunities to respond to any allegations made.

How will the final decision be made?

If the board of governors is content that a full and proper process has been followed, it should vote on the matter. If there is any doubt whatsoever in relation to the process, the board of governors must seek clarification and remedy any deficiencies before voting.

Removal requires the approval of a majority of the board of governors at a general meeting.

What are the next steps following removal?

When the board of governors ends an auditor's appointment in disputed circumstances, the Chair of the NHS foundation trust should write to Monitor informing it of the reasons behind the decision. In all cases of removal, the NHS foundation trust will need to appoint a new auditor.

The removal process and the reasons for it will need to be set out in the NHS foundation trust's annual report.

7 Receiving the NHS foundation trust's annual accounts, any report of the auditor on them, and the annual report

In order to keep the board of governors informed of what is going on at the NHS foundation trust, certain documents must be presented to it.

The chapter looks at what documents should be provided to the board of governors as a minimum and to meet the statutory requirements.

Issues that we will look at in this chapter include:

- the role of the governor in receiving these documents; and
- internal feedback requirements.

"We educate our governors intensively in how foundation trust accounts work. Without this, how would they be able to ask the right questions?"

What are the legal requirements?

The legislation states: "The following documents must be presented to the board of governors… at a general meeting:

(a) the annual accounts,

(b) any report of the auditor on them; and

(c) the annual report."

What are these documents?

Further detail in relation to the annual report and accounts of an NHS foundation trust (including any report of the NHS foundation trust's auditor in relation to the accounts) can be found in the *NHS Foundation Trust Financial Reporting Manual (Financial Reporting Manual),* available on Monitor's website.

General

The annual report and accounts must be formally approved by the board of directors. Once they have been approved, the auditor will sign its opinion on the accounts (in accordance with the *Audit Code*). The auditor will need to see the annual report prior to signing its opinion.

NHS foundation trusts are required to lay their annual report and accounts (with any report of the auditor on them) before Parliament. The *Financial Reporting Manual* sets out a timetable for this.

Accounts

The NHS foundation trust must keep accounts, prepare in respect of each financial year annual accounts and comply with any directions given by Monitor in respect of certain aspects of those accounts.

Auditor's report on the accounts

When the auditor has concluded its audit of the accounts, it must enter on the accounts:

- a certificate that it has completed the audit in accordance with the applicable legislation; and
- an opinion on the accounts.

The certificate and opinion should be addressed to the board of governors. The certificate must confirm that the audit has been completed in accordance with the requirements of the legislation. If the auditor has completed the audit in accordance with these requirements but has been unable to satisfy itself in relation to certain of the matters set out in the *Audit Code*, it must state this in the certificate by qualifying the certificate.

Annual report and accounts

The *Financial Reporting Manual* sets out the requirements for the content and format of the annual report and accounts.

The accounts will include:

- a statement of the accounting officer's responsibilities;
- a statement on internal control;
- auditors' opinion;
- main statements; and
- notes.

As a minimum, the annual report will include:

- a directors' report including a management commentary;
- a remuneration report;
- the disclosures set out in the *Code of Governance*; and
- other disclosures in the public interest.

In addition, the annual report must include a report on the quality of care the NHS foundation trust provides. The quality report contains a quality narrative, incorporating a statement signed by the Chief Executive outlining the current position on quality and the priorities for improving quality within the trust.

"Our trust has invested heavily in ensuring all governors are sufficiently trained in this area"

In addition to the quality narrative, the report summarises the trust's performance against quality indicators selected by the trust in three key areas:

- patient safety;
- clinical effectiveness; and
- patient experience.

Further details in relation to all of these matters are set out in the *Financial Reporting Manual* and governors are encouraged to read this.

What is the role of the governors?

As indicated, the annual report and accounts and auditor's report on the accounts must be presented to the board of governors at a meeting of the board of governors.

This meeting should be convened within a reasonable timescale after the end of the financial year in question but *must not* be before the annual report and accounts have been laid before Parliament.

The *Financial Reporting Manual* suggests that an advertisement be placed in the local media not less than 14 days prior to the date of the meeting, stating:

- the time, date and location of the meeting; and
- that copies of the annual report and accounts (or annual report and summary financial statements) of the NHS foundation trust are available, on request, prior to the meeting and how copies can be obtained.

What does "presented" mean?

Each of the above documents provides important information in relation to the NHS foundation trust's performance.

The presentation of these documents to the board of governors is important as it informs governors in relation to their other statutory duties (for example, the performance of the Chair or the other non-executive directors), allows them to provide informed feedback to the board of directors and enables them to inform external stakeholders (including any that they represent) on how the NHS foundation trust is performing.

Internal feedback

The point at which the document, referred to in this chapter, are presented to the board of governors may be a good opportunity for the board of directors to brief the board of governors on the overall performance (financial and otherwise) of the NHS foundation trust in the previous year.

The board of governors should also provide feedback to the board of directors in light of the overall performance of the NHS foundation trust.

The responsibility for arranging such provision of information should rest with the Chair.

External stakeholders

As well as providing feedback to the board of directors, the board of governors should explain to the constituencies and the stakeholder organisations that either elected them or appointed them, how the NHS foundation trust has performed over the previous year. This may be done around the time of the annual report and accounts.

8 Preparing the forward plan

As well as having a role in relation to the current performance of the NHS foundation trust, the board of governors should also be involved in strategic planning.

This chapter describes this requirement in further detail.

Issues that we will look at in this chapter include:

- what is the forward plan?;
- the governors' role in strategic planning; and
- what the board of directors does in relation to governors' input.

What are the legal requirements?

Under the terms of the legislation the NHS foundation trust must give Monitor forward planning information in respect of each financial year.

This must be prepared by the board of directors. Nonetheless, the legislation gives the board of governors a role in relation to this. The legislation states that:

"In preparing the document the directors must have regard to the views of the board of governors".

This means that it is therefore for discussion and not approval.

What is the forward plan?

Monitor's *Compliance Framework* sets out its approach to compliance by NHS foundation trusts with their terms of authorisation. As part of this, Monitor requires each NHS foundation trust to submit an annual plan including forecast financial performance, details of any major risks to compliance with their terms of authorisation and how the NHS foundation trust intends to address these. This will also include forward planning information for publication.

Further advice in the preparation of the annual plan submissions can be found in Monitor's *Annual Plan: Advice for NHS Foundation Trusts,* which is updated annually.

The information provided in the annual plan includes:

- commentary on the strategic overview for the NHS foundation trust, changes to previous forecasts, risk analysis and membership plans;
- a membership report;
- board statements on risk, service performance, clinical quality, compliance with the terms of Authorisation and board roles, structure and capacity;
- financial projections; and
- updates in relation to Schedules 2 (mandatory goods and services) and 3 (mandatory education and training) of the NHS foundation trust's terms of Authorisation.

The NHS foundation trust will need to make clear the elements of its annual plan that do not constitute forward planning information for publication.

"Governors feed back to members through constituency meetings which are held periodically. People know their opinions are sought and valued"

What is the role of the governors?

When evaluating the role of the governors in relation to the forward plan, it is important to be reminded of the overall role of governors which is to:

- hold the board of directors to account for the performance of the trust; and
- represent the members' interests and bring these to bear on strategic decisions.

Preparing the forward plan encompasses the latter of these two primary responsibilities.

The forward plan incorporates both operational and strategic information. The role of the board of governors is to ensure that the interests of members are considered when strategic developments are proposed.

This role may be performed in various ways but the key stages are outlined below.

Canvassing members' opinions

Governors should ensure that the opinions of their members are canvassed, thus ensuring full participation in the planning process. This can be achieved using various methods such as holding constituency meetings or open days and should be done throughout the year. Some NHS foundation trusts are considering offering secretarial support to their governors to facilitate such exchange of information.

Discussing planning priorities with the board of directors

Governors must then feed back the views of their members to the board of directors. This has been achieved in a variety of ways by NHS foundation trusts to date. A non-exhaustive list of processes is provided below:

- holding strategic planning events with both boards present;
- the board of governors presenting their priorities to the board of directors for consideration; and
- the board of directors providing the governors with their planning intentions and asking the board of governors to rank the strategic initiatives in importance.

Involvement of governors in strategic development plans

After a specific development has been approved by the board of directors (and incorporated into the forward plan for the trust) the governor involvement should continue to ensure that the interests of members remain represented. To be clear, this does not mean that governors are involved in the operational planning of each initiative developed by the trust, rather that individual options for strategic developments are considered by governors at a higher level and members' considerations are discussed.

What should the board of directors do in relation to governors' input?

Forward planning remains the responsibility of the board of directors. As such, it may be that not all of the comments of the board of governors will be incorporated into the final forward plan.

Nonetheless, in this context, the board of directors must give the board of governors' views some weight. The amount of weight given is up to the board of directors – but the governors' views must, at least, be considered. The board of directors should consider presenting a report to the board of governors identifying where governor opinion has been accepted and incorporated into the forward plan and feeding back on areas where opinion could not be fully incorporated.

Annual plan: Advice for NHS foundation trusts provides further guidance as to how the annual plan should demonstrate the process for incorporating the views of governors.

Informing stakeholders

The board of governors should inform stakeholders of the NHS foundation trust's forward planning and the reasoning behind it.

This should be done after submission of forward planning information to Monitor.

9 Looking ahead

This guide has set out some of the key statutory and other responsibilities of the board of governors. However, good practice exists in many other areas. NHS foundation trusts are encouraged to utilise the various networks to access best practice and drive continuous improvements.

Useful links

Monitor's website contains copies of all publications mentioned in this guide

- *Model Core Constitution;*
- *Code of Governance;*
- *Audit Code;*
- *NHS Foundation Trust Financial Reporting Manual (FReM);*
- *Compliance Framework; and*
- *Annual Plan: Advice for NHS Foundation Trusts.*

There is also a section for governors on Monitor's website which provides general information, as well as details of events and useful links.

Foundation Trust Network:
http://www.nhsconfed.org/NETWORKS/FOUNDATIONTRUST/Pages/home.aspx

Foundation Trust Governors' Association:
http://www.ftgovernors.org.uk/

Acknowledgements

We are very grateful to the following NHS foundation trusts that have contributed to this guide:

[2]gether NHS Foundation Trust
Aintree University Hospitals NHS Foundation Trust
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Calderdale and Huddersfield NHS Foundation Trust
Cambridge University Hospitals NHS Foundation Trust
Central and North West London NHS Foundation Trust
Clatterbridge Centre for Oncology NHS Foundation Trust
Derby Hospitals NHS Foundation Trust
Dorset County Hospital NHS Foundation Trust
East London NHS Foundation Trust
Frimley Park Hospital NHS Foundation Trust
Gloucestershire Hospitals NHS Foundation Trust
Harrogate and District NHS Foundation Trust
Homerton University Hospital NHS Foundation Trust
King's College Hospital NHS Foundation Trust
Lancashire Care NHS Foundation Trust
Lancashire Teaching Hospitals NHS Foundation Trust
Lincolnshire Partnership NHS Foundation Trust
Luton and Dunstable Hospital NHS Foundation Trust
Medway NHS Foundation Trust
Mid Cheshire Hospitals NHS Foundation Trust
Moorfields Eye Hospital NHS Foundation Trust
Norfolk and Norwich NHS Foundation Trust
North Essex Partnership NHS Foundation Trust
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust
Northumbria Healthcare NHS Foundation Trust
Oxleas NHS Foundation Trust
Peterborough and Stamford Hospitals NHS Foundation Trust
Poole Hospital NHS Foundation Trust
Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust
Royal Berkshire NHS Foundation Trust
Royal Bolton Hospitals NHS Foundation Trust
Royal Orthopaedic Hospital NHS Foundation Trust
Salford Royal NHS Foundation Trust
Salisbury NHS Foundation Trust
Sheffield Health & Social Care NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust
Somerset Partnership NHS Foundation Trust
South Essex Partnership University NHS Foundation Trust
South Staffordshire and Shropshire Healthcare NHS Foundation Trust
Southend University Hospitals NHS Foundation Trust
Taunton & Somerset NHS Foundation Trust
Tavistock and Portman NHS Foundation Trust
The Newcastle Upon Tyne Hospitals NHS Foundation Trust
The Rotherham NHS Foundation Trust
University College London Hospitals NHS Foundation Trust
University Hospitals of Birmingham NHS Foundation Trust

10 Consultation questions

We welcome feedback on this draft document. In this chapter you can find details of how to respond to the consultation and a list of the consultation questions.

Consultation questions

We welcome feedback on this draft document.

Below are the consultation questions. You can find these on our website and respond in any of the following ways:

- by completing an online form on our website: www.monitor-nhsft.gov.uk
- by downloading a document containing the questions on our website and then emailing your responses to consultation@monitor-nhsft.gov.uk
- by sending your responses, with your full contact details, to us at the following address:

  Consultation on Guide for Governors
  Monitor
  4 Matthew Parker Street
  London
  SW1H 9NP

- by faxing your responses, with your full contact details, to us to 020 7340 2401.

This consultation launched on Monday 20 April 2009 and runs for 12 weeks. Please submit your responses by 5pm, Monday 13 July 2009.

Consultation questions

The governance structure within NHS foundation trusts

1. Does the chapter on governance structure explain in principle the key elements of a foundation trust? If not, which elements require further explanation?

2. Are there other useful committees/roles you feel should be covered in this section? Are the terms used in the guide clear?

The role of a governor

3. Are the statutory duties of the board of governors explained clearly? If not, how would you improve this?

The governors and the chair (and non-executive directors)

4. Do you agree that governors should be involved in performance appraisals for the chair and non-executive directors? If not, what information should governors have when considering issues such as re-appointment or removal?

5. Was the process for appointing a chair sufficiently clear? If not, what additional elements or clarification would be helpful?

6. Does the guide provide clarity over setting terms and conditions for all non-executive directors, including the chair? If not, what further guidance would aid the process?

7. Do you agree with the suggested process for removal?

Approving the appointment of the chief executive

8. Is the process for approving the appointment of the chief executive clear? If not, how would you improve this?

The governors and the NHS foundation trust auditor

9. Does the chapter on appointing and removing the auditor explain the key requirements of the board of governors? What additional information would be helpful?

Receiving the NHS foundation trust's accounts

10. Does this chapter provide useful guidance for governors? Is further explanation required?

The forward plan

11. Is the board of governors' role in preparing the forward plan clearly explained in the guidance?

General

12. Is the guide written in a concise and clear manner?

13. Are the statutory duties of the board of governors clearer to you after reading the guide?

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Consultation questions on the draft document, *Guide for NHS foundation trust governors: meeting your statutory responsibilities*

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