Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting

Boardroom
Chair: Juggy Pandit
Date: 23rd November 2006
Time: 4:30pm

Agenda

1. GENERAL BUSINESS	**4.30pm**
1.1 Apologies for Absence	**JP**
1.2 Register of Council Members	**JP**
1.3 Register of Interests	**JP**
1.4 Chairman's Report (attached)	**JP**
2. ITEMS FOR DECISION/APPROVAL	
2.1 Code of Conduct for the Members' Council (attached)	**JP**
2.2 Standing Orders for the Members' Council (attached)	**JP**
2.3 Ratification of Appointments (attached)	**JP**
2.4 Appointment of a Deputy Chair of the Members' Council (attached)	**JP**
2.5 Vacancies on the Members' Council (attached)	**JP**
2.6 Communication Requirements (attached)	**JP**
3. ITEMS FOR INFORMATION	
3.1 Monitor Terms of Authorisation (attached)	**JP**
3.2 Monitor NHS Foundation Trust Code of Governance (attached)	**JP**
3.3 Roles and Responsibilities of Members' Council (attached)	**JP**
3.4 Finance and Report (attached)	**LB**
3.5 Performance Report (attached)	**LB**
3.6 Senior Independent Director (attached)	**JP**
3.7 Process for Establishing a Nominations Committee – Oral Report	**JP**
3.8 Disability Equality Scheme (attached)	**AP**
3.9 Schedule of Meetings (attached)	**JP**
3.10 Members' Council Development Needs – Oral Report	**JP**
3.11 Open Day – Oral Report	**HL**
3.12 Information Requirements – Oral Report	**JP**
4. ANY OTHER BUSINESS	
5. DATE OF THE NEXT MEETING	

Members' Council Meeting, 23rd November 2006

AGENDA ITEM NO.	1.4/Nov/06
PAPER	Chairman's Report
AUTHOR	Juggy Pandit, Chairman
LEAD	Juggy Pandit, Chairman
SUMMARY	This report outlines key issues for the attention of the Members' Council.
DECISION/ ACTION	The Council is asked to note the report.

CHAIRMAN'S REPORT

On behalf of the Trust and myself I would like to welcome everyone to the inaugural Members' Council meeting. This report will detail key discussions at the Trust Board as well as report any other issues for the attention of the Members' Council.

BOARD OF DIRECTORS

The most recent meeting of the Board was held on November 2nd. Key issues for discussion for the attention of the Council were as follows:

Annual Planning: The Trust is required to submit to Monitor an Annual Plan at the end of May for that financial year which commences on April 1st. The Plan identifies the key information that Monitor requires to assess the scale of the Trust's risk of breaching its terms of authorisation in relation to finance, governance and mandatory services. The planning cycle for 2007/08 will commence shortly and the Members' Council will be involved in this process. Please let me know if you wish to be involved.

Director of Strategy and Service Planning: The Trust has recently recruited to this post which has been vacant since the beginning of the year. Mr Ahmet Khutti who is currently at the Prime Minster's Delivery Unity will start in February and until that time Ms Rebecca Manvell, Strategy Officer from the SHA has been seconded to lead on annual planning.

Picture Archiving and Communications System (PACS): The Board recently approved the installation of PACS which allows images such as x-rays and scans to be stored electronically and then viewed via computer or television screen. This will allow the Trust to provide a more efficient and timely service and it will also enhance communication with other Trusts. The system will begin testing in February/March and should go live early next financial year.

Monitor Quarterly Reporting: As part of the Monitor authorisation process the Trust is required to submit a Quarterly Report to determine the Trust's Finance, Governance and Mandatory Services Risk Ratings. These ratings are set annually by Monitor based in information provided in the Trust's Annual Plan. On authorisation, The Trust scored 4 for Finance (the highest score possible for a new Foundation Trust), amber for Governance and green for Mandatory Services (these latter two use a red, amber, green traffic light system).

As it is planned to hold the Members' Council meetings quarterly, a summary of all of that quarter's Board meetings will be provided in future reports.

COUNCIL ISSUES

As this is our first meeting, there will be a number of governance and procedural issues to address which are detailed in the attached papers. As I have yet to have a chance to meet some of you, I will endeavour to sit down with each of you individually over the coming months to learn more about your interests and experience. Fleur will circulate possible dates soon after the meeting.

Juggy Pandit
Chairman
13th November 2006

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 23rd November 2006

AGENDA ITEM NO.	2.1/Nov/06
PAPER	Draft Code of Conduct
AUTHOR	Fleur Hansen, Foundation Trust Lead
LEAD	Juggy Pandit, Chair
SUMMARY	The paper lays out a draft Code of Conduct that Council Members' should abide by. The Members' Council are asked to discuss the Code and amend if required.
DECISION/ ACTION	The Members' Council is asked to agree and adopt the Code of Conduct.

DRAFT MEMBERS' COUNCIL CODE OF CONDUCT

Council Members agree to abide by the following Code of Conduct.

All Council Members will:

1. Act in accordance with the Seven Principles of Public Life (Nolan) (attached).
2. Agree to support and contribute to the Trust.
3. Act in the best interests of the Trust at all times.
4. Allow no political, religious, or sectarian affiliations to influence any decisions to which they are party.
5. Refrain from actions or communications that could bring the Trust into disrepute.
6. Declare all perceived conflicts of interest, and to refrain from discussions and votes (subject to invitation from Chairman or Sub-committee chairman) if appropriate.
7. Maintain confidentiality of matters not in the public domain at all times.
8. Represent the best interests of their constituencies or partner organisations in all discussions of the Members' Council and its sub-committees.
9. Act to ensure compliance with all ethical and legal requirements.
10. Abide by the Members' Council standing orders, policies and procedures.
11. Attend meetings of the Members' Council and relevant sub-committees.
12. Undertake training and receive guidance in respect of their responsibilities.
13. Ensure that fellow Council Members are valued as colleagues and respect their opinions.

*The Code will be reviewed annually.

The Seven Principles of Public Life (Nolan)

Selflessness
Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

Integrity
Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity
In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness
Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership
Holders of public office should promote and support these principles by leadership and example.

Members' Council Meeting, 23rd November 2006

AGENDA ITEM NO.	2.2/Nov/06
PAPER	Standing Orders for the Members' Council
AUTHOR	Fleur Hansen, Foundation Trust Lead
LEAD	Juggy Pandit, Chair
SUMMARY	The Trust's Constitution requires that the Members' Council adopts its own Standing Orders for its practice and procedure (paragraph 12.10.8). These Standing Orders have been drafted from the relevant sections of the Trust's Constitution.
DECISION/ ACTION	The Council is asked to approve and adopt the Standing Orders.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

STANDING ORDERS

MEMBERS' COUNCIL

NOVEMBER 2006

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1. Interpretation

1.1. Unless the contrary intention appears or the context otherwise requires, words or expressions contained in this constitution bear the same meaning as in the Health and Social Care (Community Health and Standards) Act 2003.

1.2. References in this constitution to legislation include all amendments, replacements, or re-enactments made.

1.3. Headings are for ease of reference only and are not to affect interpretation.

1.4. Words importing the masculine gender only shall include the feminine gender; words importing the singular shall include the plural and vice-versa.

1.5. In this constitution:

"the 2003 Act" means the Health and Social Care (Community Health and Standards) Act 2003;

"the 1977 Act" means the National Health Service Act 1977;

"appointed Council Members" means those Council Members appointed by the appointing organisations;

"appointing organisations" means those organisations named in this constitution who are entitled to appoint Council Members;

"areas of the Foundation means the eight areas specified in Trust" Annex 1 which are Royal Borough of Kensington and Chelsea (areas 1 and 2), the City of Westminster (areas 1 and 2), the London Borough of Hammersmith and Fulham (areas 1 and 2) and the London Borough of Wandsworth (areas 1 and 2);

"authorisation" means an authorisation given by the Independent Regulator;

"Board of Directors" means the Board of Directors as constituted in accordance with this constitution;

"carer" means a person who has attended any of the Foundation Trust's facilities as the carer of a patient in the last three years and is registered as a carer by the Foundation Trust, provided that such person is not providing care in pursuance of a contract (including a contract of employment), or as a volunteer for a voluntary organisation (being a body other than a public or local authority the activities of which are not carried on for profit);

"Director" means a member of the Board of Directors;

"elected Council Members" means those Council Members elected by the public constituencies, the patients' constituency and the classes of the staff constituency;

"external auditor" means any external auditor other than the financial auditor appointed under this constitution to review and report upon other aspects of the Foundation Trust's performance;

"financial auditor" means the person appointed to audit the accounts of the Foundation Trust, who is called the auditor in the 2003 Act;

"Financial year" means:

(a) the period beginning with the date on which the Foundation Trust is authorised and ending with the next 31 March; and

(b) each successive period of twelve months beginning with 1 April;

"the Foundation Trust" means Chelsea and Westminster Hospital NHS Foundation Trust;

"Independent Regulator" means the regulator for the purposes of Part 1 of the 2003 Act;

"Local Authority Council Member" means a Council Member appointed by one or more local authorities whose area includes the whole or part of one of the areas of the Foundation Trust;

"member" means a member of the Foundation Trust;

"Members' Council" means the Members' Council as constituted in accordance with this constitution, which has the same meaning as the board of governors in the 2003 Act;

"the NHS Trust" means Chelsea and Westminster Hospital NHS Trust which made the application to become an NHS foundation trust

"partner" means, in relation to another person, a member of the same household living together as a family unit;

"Partnership Council Member" means a Council Member appointed by a partnership organisation;

"patient" means a person who has attended any of the Foundation Trust's facilities as a patient in the last three years;

"patients' constituency" means (collectively) those members comprising the patients' constituency;

"Patient Council Member" means a member of the Members' Council elected by the patients' constituency;

"PCT Council Member" means a Council Member appointed by a Primary Care Trust for which the Foundation Trust provides goods or services;

"public constituency" means (collectively) those members living in one of the areas of the Foundation Trust;

"Public Council Member" means a Council Member elected by the members of one of the public constituencies;

"registered dentist" means a registered dentist within the meaning of the Dentists Act 1984;

"registered medical practitioners means a fully registered person within the meaning of the Medicines Act 1983 who holds a licence to practice under that Act;

"Secretary" means the Secretary of the Foundation Trust or any other person appointed to perform the duties of the Secretary, including a joint, assistant or deputy secretary;

"staff constituency" means (collectively) those members of the six classes comprising the staff constituency;

"Staff Council Member" means a Council Member elected by the members of one of the classes of the staff constituency;

"University Council Member" means a Council Member appointed by Imperial College, University of London.

2 Eligibility to be a Council Member

2.1 A person may not become a Council Member of the Foundation Trust, and if already holding such office will immediately cease to do so, if:

2.1.1 they are under sixteen years of age;

2.1.2 they are a Director of the Foundation Trust, or a governor or director of a health service body (unless they are appointed by an appointing organisation which is a health service body);

2.1.3 they are the spouse, partner, parent or child of a member of the Board of Directors of the Foundation Trust;

2.1.4 they are a member of a local authority's Overview and Scrutiny Committee covering health matters;

2.1.5 being a member of one of the public constituencies or the patients' constituency, they refuse to sign a declaration in the form specified by the Secretary of particulars of their qualification to vote as a member of the Foundation Trust, and that they are not prevented from being a member of the Members' Council;

2.1.6 if they are subject to a sex offender order;

2.1.7 they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;

2.1.8 they have made a composition or arrangement with, or granted a trust deed for, their creditors and have not been discharged in respect of it;

2.1.9 they have within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed;

2.1.10 they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

2.1.11 they are a person whose tenure of office as the Chairman or as a member or director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

2.1.12 they are a member of the Foundation Trust's Patients' Forum.

3 Composition of the Members' Council

3.1 The Foundation Trust is to have a Members' Council. It is to consist of Public Council Members, Patient Council Members, Staff Council Members, PCT Council Members, Local Authority Council Members, a University Council Member and Partnership Council Members.

3.2 The aggregate number of Public Council Members and Patient Council Members is to be more than half of the total number of members of the Members' Council.

3.3 The Members' Council, subject to the 2003 Act, shall seek to ensure that through the composition of the Members' Council:

3.3.1 the interests of the community served by the Foundation Trust are appropriately represented;

3.3.2 the level of representation of the public constituencies, the patients' constituency and the classes of the staff constituency and the appointing organisations strikes an appropriate balance having regard to their legitimate interest in the Foundation Trust's affairs;

and to this end, the Members' Council:

3.3.3 shall at all times maintain a policy for the composition of the Members' Council which takes account of the membership strategy, and

3.3.4 shall from time to time and not less than every three years review the policy for the composition of the Members' Council, and

3.3.5 when appropriate shall propose amendments to this constitution.

3.4 The Members' Council of the Foundation Trust is to comprise:

3.4.1 eight Public Council Members from the following public constituencies:

3.4.1.1 Royal Borough of Kensington and Chelsea (area 1) - one Public Council Member;

3.4.1.2 Royal Borough of Kensington and Chelsea (area 2) - one Public Council Member;

3.4.1.3 City of Westminster (area 1) - one Public Council Member;

3.4.1.4 City of Westminster (area 2) - one Public Council Member;

3.4.1.5 London Borough of Hammersmith and Fulham (area 1) – one Public Council Member;

3.4.1.6 London Borough of Hammersmith and Fulham (area 2) – one Public Council Member;

3.4.1.7 London Borough of Wandsworth (area 1) – one Public Council Member;

3.4.1.8 London Borough of Wandsworth (area 2) – one Public Council Member;

3.4.2 ten Patient Council Members;

3.4.3 six Staff Council Members from the following classes;

3.4.3.1 Support, Administrative and Clerical staff – one Staff Council Member;

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

3.4.3.3 Contracted staff – one Staff Council Member;

3.4.3.4 Medical and Dental staff – one Staff Council Member;

3.4.3.5 Nursing and midwifery – one Staff Council Member;

3.4.3.6 Management – one Staff Council Member;

3.4.4 four PCT Council Members, one to be appointed by each of: Kensington and Chelsea PCT, Hammersmith and Fulham PCT, Westminster PCT and Wandsworth PCT;

3.4.5 two Local Authority Council Members to be appointed by Westminster City Council, and the Royal Borough of Kensington and Chelsea;

3.4.6 one University/Medical School Council Member to be appointed by Imperial College, University of London;

3.4.7 three Partnership Council Members to be appointed by partnership organisations.

3.5 The partnership organisations that may each appoint a Partnership Council Member are:

3.5.1 Thames Valley University;

3.5.2 the Royal Marsden NHS Foundation Trust;

3.5.3 the Royal Brompton and Harefield NHS Trust.

4 Election/Appointment of Council Members

4.1 Public Council Members are to be elected by members of their public constituency, Patient Council Members are to be elected by members of the patients' constituency and Staff Council Members are to be elected by members of their class of the staff constituency. Each class/constituency may elect any of their number to be a Council Member in accordance with the provisions of this constitution.

4.2 If contested, the elections must be by secret ballot.

4.3 Elections shall be carried out in accordance with the rules set out in Annex 2. The Members' Council will decide which of the two voting methods set out in Annex 2 is to be used.

4.4 A member of a public constituency or the patients' constituency may not vote at an election for a Public Council Member or a Patient Council Member (as the case may be) unless within twenty-one days before they vote they have made a declaration in the form specified by the Secretary that they are qualified to vote as a member of the relevant public constituency or patients' constituency. It is an offence to knowingly or recklessly make such a declaration which is false in a material particular.

4.5 PCT Council Members: The Secretary, having consulted Kensington and Chelsea PCT, Westminster PCT, Hammersmith and Fulham PCT and Wandsworth PCT, is to adopt a process for agreeing the appointment of PCT Council Members with those Primary Care Trusts.

4.6 Local Authority Council Members: The Secretary, having consulted Westminster City Council and the Royal Borough of Kensington and Chelsea, is to adopt a process for agreeing the appointment of Local Authority Council Members with those local authorities.

4.7 University Council Members: The Secretary, having consulted Imperial College, University of London, is to adopt a process for agreeing the appointment of University Council Members with Imperial College, University of London.

4.8 Partnership Council Members: The Partnership Council Members are to be appointed by the partnership organisations, in accordance with a process agreed with the Secretary.

5 Roles and Responsibilities

5.1 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:

5.2 at a General Meeting:

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

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

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

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

5.2.5 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;

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

5.3 to provide their views to the Board of Directors when the Board of Directors is preparing the document containing information about the Foundation Trust's forward planning;

5.4 to respond as appropriate when consulted by the Board of Directors in accordance with this constitution;

5.5 to undertake such functions as the Board of Directors shall from time to time request;

5.6 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;

5.7 when appropriate to make recommendations for the revision of this constitution.

6 Appointment of Deputy Chairman of the Members' Council

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

7 Terms of office for Council Members

7.1 Elected Council Members:

7.1.1 shall normally hold office for a period of three years commencing immediately after the annual members meeting at which their election is announced;

7.1.2 are eligible for re-election at the end of that period;

7.1.3 may not hold office for more than nine consecutive years, and shall not be eligible for re-election if they have already held office for more than six consecutive years .

7.2 Appointed Council Members:

7.2.1 shall normally hold office for a period of three years commencing immediately after the annual members meeting at which their appointment is announced;

7.2.2 are eligible for re-appointment at the end of that period;

7.2.3 may not hold office for longer than nine consecutive years, and shall not be eligible for re-appointment if they have already held office for more than six consecutive years.

7.3 For the purposes of these provisions concerning terms of office for Council Members, "year" means a period commencing immediately after the conclusion of the annual members meeting, and ending at the conclusion of the next annual members meeting.

8 Termination of office and removal of Council Members

8.1 A person holding office as a Council Member shall immediately cease to do so if:

8.1.1 they resign by notice in writing to the Secretary;

8.1.2 they fail to attend three consecutive meetings, unless the other Council Members are satisfied that:

8.1.2.1 the absences were due to reasonable causes; and

8.1.2.2 they will be able to start attending meetings of the Members' Council again within such a period as the other Council Members consider reasonable;

8.1.3 in the case of an elected Council Member, they cease to be a member of the constituency or class of the constituency by which they were elected;

8.1.4 in the case of an appointed Council Member, the appointing organisation terminates the appointment;

8.1.5 they have refused without reasonable cause to undertake any training which the Members' Council requires all Council Members to undertake;

8.1.6 they have failed to sign and deliver to the Secretary a statement in the form required by the Secretary confirming acceptance of the code of conduct for Council Members;

8.1.7 they are removed from the Members' Council under the following provisions.

8.2 A Council Member may be removed from the Members' Council by a resolution approved by not less than three-quarters of the remaining Council Members present and voting on the grounds that:

8.2.1 they have committed a serious breach of the code of conduct, or

8.2.2 they have acted in a manner detrimental to the interests of the Foundation Trust, and

8.2.3 the Members' Council consider that it is not in the best interests of the Foundation Trust for them to continue as a Council Member.

9 Vacancies amongst Council Members

9.1 Where a vacancy arises on the Members' Council for any reason other than expiry of term of office, the following provisions will apply.

9.2 Where the vacancy arises amongst the appointed Council Members, the Secretary shall request that the appointing organisation appoints a replacement to hold office for the remainder of the term of office.

9.3 Where the vacancy arises amongst the elected Council Members, the Members' Council shall be at liberty either:

9.3.1 to call an election within three months to fill the seat for the remainder of that term of office, or

9.3.2 to invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat until the next annual election, at which time the seat will fall vacant and subject to election for any unexpired period of the term of office.

10 Members' Council Meetings

10.1 The Members' Council is to meet at least four times in each financial year. Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least fourteen days written notice of the date and place of every meeting of the Members' Council to all Council Members. Notice will also be published in a local newspaper or newspapers circulating in the area served by the Foundation Trust, and on the Foundation Trust's website.

10.1 Meetings of the Members' Council may be called by the Secretary, or by the Chairman, or by ten Council Members (including at least two elected Council Members and two appointed Council Members) who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Council Members as soon as possible after receipt of such a request. The Secretary shall call a meeting on at least fourteen but not more than twenty-eight days' notice to discuss the specified business. If the Secretary fails to call such a meeting then the Chairman or ten Council Members, whichever is the case, shall call such a meeting.

10.2 All meetings of the Members' Council are to be General Meetings open to members of the public unless the Members' Council decides otherwise in relation to all or part of a meeting for reasons of commercial confidentiality or on other proper grounds. The Chairman may exclude any member of the public from a meeting of the Members' Council if they are interfering with or preventing the proper conduct of the meeting.

10.3 Twelve Council Members including not less than four Public and/or Patient Council Members, not less than one Staff Council Member and not less than two appointed Council Members shall form a quorum.

10.4 The Chairman of the Foundation Trust or, in their absence, the Vice Chairman of

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

10.5 The Members' Council may invite the Chief Executive or any other member or members of the Board of Directors, or a representative of the financial auditor or other advisors to attend a meeting of the Members' Council.

10.6 The Members' Council may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

10.7 Subject to this constitution and the following provisions of this paragraph, questions arising at a meeting of the Members' Council shall be decided by a majority of votes.

10.8 In case of an equality of votes the person presiding at or chairing the meeting shall have a casting vote.

10.9 No resolution of the Members' Council shall be passed if it is opposed by all of the Public Council Members present.

10.10 The Members' Council may not delegate any of its powers to a committee or sub-committee, but it may appoint committees consisting of its members, Directors, and other persons to assist the Members' Council in carrying out its functions. The Members' Council may, through the Secretary, request that advisors assist them or any committee they appoint in carrying out its duties.

10.11 All decisions taken in good faith at a meeting of the Members' Council or of any committee shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the Council Members attending the meeting.

11 Annual Members Meeting

11.1 The Foundation Trust is to hold a members meeting (called the annual members meeting) within nine months of the end of each financial year.

11.2 All members meetings other than annual meetings are called special members meetings.

11.3 Members meetings are open to all members of the Foundation Trust, Council Members and Directors, and representatives of the financial auditor, but not to members of the public unless the Members' Council decides otherwise. The Members' Council may invite representatives of the media and any experts or advisors whose attendance they consider to be in the best interests of the Foundation Trust to attend a members meeting.

11.4 All members meetings are to be convened by the Secretary by order of the Members' Council.

11.5 The Members' Council may decide where a members meeting is to be held and

may also for the benefit of members:

11.5.1 arrange for the annual members meeting to be held in different venues each year:

11.5.2 make provisions for a members meeting to be held at different venues simultaneously or at different times. In making such provision the Members' Council shall also fix an appropriate quorum for each venue, provided that the aggregate of the quorum requirements shall not be less than the quorum set out below.

11.6 At the annual members meeting the Members' Council shall present to the members:

11.6.1 a report on steps taken to secure that (taken as a whole) the actual membership of its public constituencies, the patients' constituency and of the classes of the staff constituency is representative of those eligible for such membership;

11.6.2 the progress of the membership strategy

11.6.3 any proposed changes to the policy for the composition of the Members' Council and of the non-executive Directors

11.6.4 the results of the election and appointment of Council Members and the appointment of non-executive Directors will be announced.

11.7 Notice of a members meeting is to be given:

11.7.1 by notice to all members;

11.7.2 by notice prominently displayed at the head office and at all of the Foundation Trust's places of business; and

11.7.3 by notice on the Foundation Trust's website at least 14 clear days before the date of the meeting. The notice must:

11.7.4 be given to the Members' Council and the Board of Directors, and to the financial auditor;

11.7.5 state whether the meeting is an annual or special members meeting;

11.7.6 give the time, date and place of the meeting; and

11.7.7 indicate the business to be dealt with at the meeting.

11.8 Before a members meeting can do business there must be a quorum present. Except where this constitution says otherwise a quorum is one member present from each of the Foundation Trust's constituencies.

11.9 The Foundation Trust may make arrangements for members to vote by post, or by using electronic communications.

11.10 It is the responsibility of the Members' Council, the Chairman of the meeting and the Secretary to ensure that at any members meeting:

11.10.1 the issues to be decided are clearly explained;

11.10.1sufficient information is provided to members to enable rational discussion to take place.

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

11.12 If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such time and place as the Members' Council determine. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of members present during the meeting is to be a quorum.

11.13 A resolution put to the vote at a members meeting shall be decided upon by a poll.

11.14 Every member present and every member who has voted by post or using electronic communications is to have one vote. In the case of an equality of votes the Chairman of the meeting is to have a second or casting vote.

11.15 The result of any vote will be declared by the Chairman and entered in the minute book. The minute book will be conclusive evidence of the result of the vote.

12 Board Appointments

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

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

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

12.1.3 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;

12.1.4 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;

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

12.2.1 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.

12.2.2 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.

12.2.3 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;

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

12.3.1 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.

12.3.2 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.

12.3.3 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.

12.3.4 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.

13 Nominations Committee

13.1 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.

14 Expenses and remuneration of Council Members

14.1 The Foundation Trust may reimburse Council Members for travelling and other costs and expenses incurred in carrying out their duties at such rates as the Board of Directors decides.

14.2 Council Members are not to receive remuneration.

15 Disclosure of interests

15.1 Any Council Member who has a material interest in a matter as defined below shall declare such interest to the Members' Council and:

15.1.1 shall withdraw from the meeting and play no part in the relevant discussion or decision

15.1.2 shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

15.2 Any Council Member who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a majority of the remaining Council Members.

15.3 Subject to the exceptions below, a material interest is:

15.3.1 any directorship of a company;

15.3.2 any interest or position held by a Council Member in any firm or company or business which, in connection with the matter, is trading with the Foundation Trust, or is likely to be considered as a potential trading partner with the Foundation Trust;

15.3.3 any interest in an organisation providing health and social care services to the National Health Service;

15.3.4 a position of authority in a charity or voluntary organisation in the field of health and social care;

15.3.5 any connection with any organisation, entity or company considering entering into a financial arrangement with the Foundation Trust including but not limited to lenders or banks.

15.4 The exceptions which shall not be treated as material interests are as follows:

15.4.1 shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange;

15.4.2 an employment contract held by a Staff Council Member;

15.4.3 an employment contract with their PCT held by a PCT Council Member;

15.4.4 an employment contract with, or a position of authority in, a local authority held by a Local Authority Council Member;

15.4.5 an employment contract with, or a position of authority in, a university held by a University Council Member;

15.4.6 an employment contract with, or a position of authority in, a partnership organisation held by a Partnership Council Member.

15.5 The Members' Council is to adopt its own standing orders for its practice and procedure, in particular for its procedure at meetings.

Members' Council Meeting, 23rd November 2006

AGENDA ITEM NO.	2.3/Nov/06
PAPER	Ratification of Appointments
AUTHOR	Fleur Hansen, Foundation Trust Lead
LEAD	Juggy Pandit, Chair
SUMMARY	As part of the Transition Schedule to Foundation Trust status it is felt appropriate that the Members' Council ratify the appointments of the Chairman and the Non-Executive Directors of the Board.
DECISION/ ACTION	The Members' Council is asked to ratify the appointments.

RATIFICATION OF APPOINTMENTS

1.0 INTRODUCTION

One of the key roles of the Members' Council is to appoint (and remove) the Chairman of the Board of Directors, the Non-Executive Directors and the Chief Executive (details of how this is done are included in the Standing Orders item 12).

The Transition Schedule states (item 27.2) that:

> 'The power to appoint the initial Chairman (or Non-Executive Directors) of the Foundation Trust is to be exercised by appointing the Chairman (or Non-Executive Directors) of the NHS Trust, if they wish to be appointed.'

It is felt appropriate that as part of this schedule, the Members' Council ratify the following appointments as they currently stand.

2.0 APPOINTMENTS FOR RATIFICATION

		Terms of Office
Chairman of the Board of Directors:	Mr Juggy Pandit	31 October 2007 (2nd)
Non-Executive Directors:	Mrs Marilyn Frampton	31 October 2007 (2nd)
	Mr Andrew Havery	31 October 2007 (1st)
	Prof Richard Kitney	31 October 2010 (1st)
	Ms Karin Norman	31 October 2009 (1st)
	Mr Charles Wilson	31 October 2007 (2nd)

Non-Executives (including the Chairman) are only allowed two terms of office.

3.0 DECISION/ACTION REQUIRED

The Members' Council is asked to ratify the continuation of those listed above in the specified roles.

Fleur Hansen
Foundation Trust Lead
9th November 2006

Members' Council Meeting, 23rd November 2006

AGENDA ITEM NO.	2.4/Nov/06
PAPER	Appointment of the Deputy Chair of the Members' Council
AUTHOR	Fleur Hansen, Foundation Trust Lead
LEAD	Juggy Pandit, Chair
SUMMARY	In accordance with the Trust's constitution the Members' Council is required to appoint a Deputy Chair. Nominations should be forwarded in writing to the Chair (or via email to fleur.hansen@chelwest.nhs.uk) by 5pm November 21st.
DECISION/ ACTION	The Members' Council is asked to agree and appoint a Deputy Chair for the Members' Council.

APPOINTMENT OF A DEPUTY CHAIR OF THE MEMBERS' COUNCIL

1.0 INTRODUCTION

The Members' Council is required to appoint a Deputy Chair of the Members' Council as per the Trust's Constitution (item 10.11). The Council has been asked to forward their nominations in writing and the election will be made at the meeting on November 23rd.

2.0 PROCESS FOR SELECTION

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

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

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

Mr Juggy Pandit
Chair
Chelsea and Westminster NHS Foundation Trust
369 Fulham Road
London SW10 9NH

Or via email to fleur.hansen@chelwest.nhs.uk. All nominations should be received no later than 5pm on Tuesday November 21st.

2.4 If more than one expresses interest in the role, a secret ballot will take place at the meeting on November 23rd.

3.0 ROLE OF THE DEPUTY CHAIR

3.1 As per the Constitution, the Deputy Chair will be not be expected to chair Members' Council meeting in the absence of the Chair but they will be expected to chair the meeting if a conflict of interest arises (item 11.17.5):

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

3.2 The Deputy Chair will though chair any annual members meetings (or special members meetings) in the absence of the Chairman (item 10.11):

> 'The Chairman of the Foundation Trust, or in their absence the Deputy Chairman of the Members' Council, shall act as chairman at all members meetings of the Foundation Trust. If neither the Chairman nor the Deputy Chairman of the Members' Council is present, the members of the Members' Council present shall elect one of their number to be Chairman

and if there is only one Council Member present and willing to act they shall be Chairman. ‘

3.3 It is also proposed that the Deputy Chair be a member of the Nominations Committee in addition to the two Council Members that will be selected to be on the Committee.

4.0 DECISION/ACTION REQUIRED

The Members’ Council is asked to agree and appoint a Deputy Chair for the Members’ Council.

Fleur Hansen
Foundation Trust Lead
13th November 2006

Members' Council Meeting, 23rd November 2006

AGENDA ITEM NO.	2.5/Nov/06
PAPER	Vacancies on the Members' Council
AUTHOR	Fleur Hansen, Foundation Trust Lead
LEAD	Juggy Pandit, Chair
SUMMARY	The Chairman has received notice that one patient representative and one public representative (Westminster 1) have resigned from the Council and a staff representative will be commencing a post with a new Trust in December. The Council therefore are asked to decide on a process for electing three new Council Members to these posts.
DECISION/ ACTION	The Members' Council is asked to agree on a process for appointing new Members of the Council.

VACANCIES ON THE MEMBERS' COUNCIL

1.0 INTRODUCTION

The Chairman has received notice that a patient representative and a public representative (Westminster 1) have resigned from the Council. The Chairman has also been informed that the allied health professionals, scientific and technical staff representative has accepted a position at another Trust and will be resigning after this meeting.

2.0 PROCESS FOR SELECTION

The process for dealing with the vacancy of an elected Member on the Council is detailed under item 11.15.3 of the Constitution:

> 11.15.3. Where the vacancy arises amongst the elected Council Members, the Members' Council shall be at liberty either:
>
> 11.15.3.1. to call an election within three months to fill the seat for the remainder of that term of office, or
>
> 11.15.3.2. to invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat until the next annual election, at which time the seat will fall vacant and subject to election for any unexpired period of the term of office.

3.0 RECOMMENDATION

It is recommended that the Members' Council select the first option and re-run the election for both seats. This is because:

- The elections were run some time ago and the next highest polling candidates may no longer be appropriate.
- For the Staff post, the second highest polling candidate was significantly behind the elected candidate in number of votes.
- There may be increased interest in the Council as we are now an FT and there may be more members who would like to run for election.

4.0 DECISION/ACTION REQUIRED

The Members' Council is asked to agree on a process for appointing new Members of the Council.

Fleur Hansen
Foundation Trust Lead
13th November 2006

Members' Council Meeting, 23rd November 2006

AGENDA ITEM NO.	2.6/Nov/06
PAPER	Communication Requirements
AUTHOR	Matt Akid, Head of Communications
LEAD	Juggy Pandit, Chair
SUMMARY	This paper details a number of different communication issues for the attention of the Members' Council. The paper recommends the formation of a Communications Sub-Committee to facilitate communication between the Council, the members and the Trust. The paper also details a proposed work plan for the Sub-Committee. The paper also asks the Council to approve the content of the Members area of the Trust website.
DECISION/ ACTION	1. The Members' Council is asked to agree and appoint a Communications Sub-Committee. 2. The Members' Council is asked to agree the content of the Members and Members' Council areas of the website. 3. The Members' Council is asked to note the Communications Sub-Committee's Initial work plan.

COMMUNICATION REQUIREMENTS

1.0 INTRODUCTION

The Trust has an existing Membership Development and Communications Strategy which formed part of the Trust's submission to Monitor for Foundation Trust status.

The Members' Council has responsibility for further developing and reviewing the Membership Development and Communications Strategy.

The strategy includes a series of detailed actions to be addressed by the Members' Council both within its first 12 months and in the long term. This paper highlights some of these actions and proposes a way forward.

2.0 BACKGROUND

The most recent communication with Foundation Trust members was an invitation to attend the Trust AGM in September 2006 and related activities on the day including live music, hospital food tasting, seminars and exhibitions.

An attendance of approximately 400 members indicated a high level of interest – many members asked how they could be better informed about the Foundation Trust.

3.0 OBJECTIVES AND ACTIONS FROM STRATEGY

The objectives of Section 7 of the Strategy - 'Communicating with Members' – include:

- Ensure members receive appropriate communications . . . about the affairs of Chelsea and Westminster Hospital NHS Foundation Trust.
- Ensure communications are used to stimulate active membership.

Actions to be addressed by the Members' Council within its first 12 months include:

- Build on existing material to customise the communications package for members.
- Develop and maximise the potential of the Internet for information and communication.
- Establish a clear brand for membership, reviewing materials and ensuring language is clear and modern.
- Identify how Trust locations can be better used as community resources and member information points – eg improved noticeboards.
- Provide to all members relevant information about the Foundation Trust, the benefits of membership and the role of members.

4.0 ITEMS FOR DECISION

To develop further member involvement, the Members' Council is asked to approve the following actions:

4.1 Communications Sub-Committee

1. A sub-committee of the Members' Council to be established to facilitate good communication between the Members' Council, Foundation Trust members and the Trust.
2. Membership of this sub-committee to include at least one representative from each constituency of the Members' Council – a patient, member of the public, staff member and nominated representative – as well as the Trust's Head of Communications and Director of Governance & Corporate Affairs.
3. Members' Councillors interested in sitting on this sub-committee to nominate themselves at the Members' Council meeting on November 23rd.
4. This committee to have the authority to make decisions on behalf of the Members' Council on both the strategic direction of communications and specific communications activities (see the work programme below under 'Items for information and discussion') – via email and face-to-face meetings – and report back to the Members' Council on a quarterly basis.

4.2 Internet

1. The current Foundation Trust microsite to become part of the core www.chelwest.nhs.uk website.
2. This site to include biographies and photographs of all Council Members – with email contact details to improve member engagement.
3. A password protected area of the website to be established for use by Council Members only - to include full contact details for all Council Members; Members' Council agendas; Board of Directors monthly reports (Finance Report, Performance Report); patient surveys and other relevant reports; links to useful websites (Monitor, Foundation Trust Network, King's Fund network for Council Members when established). There is also potential for a 'blog' to be established so that Councillors can discuss issues in a secure online environment.

5 ITEMS FOR INFORMATION AND DISCUSSION

In addition to the items for decision outlined above, the Members' Council is asked to consider for information and discussion the following communications activities that will, it is proposed, form the basis of the sub-committee's initial work plan.

5.1 Members' newsletter

1. A newsletter to be established for all Foundation Trust members as the primary tool of communication with the membership for the Foundation Trust and Members' Council – to include news from the Trust, biographies and photographs of all Members' Councillors, details of events for members and the package of membership benefits as these come on stream.
2. This newsletter to be available via email and the Trust website for those members who prefer to receive information by email – this will reduce costs.
3. Communications Sub-Committee to advise on content.

5.2 Membership pack

1. The current membership pack and card which is sent to all new Foundation Trust members to be reviewed.
2. A clear brand for Foundation Trust materials to be established that is consistent with other corporate communications materials such as the Trust annual report.
3. Communications Sub-Committee to advise on content and brand.

5.3 Promoting membership

Consider membership benefits – i.e. promoting the value of being part of the membership and greater involvement in the Trust. Other benefits could be, for example, seminars, open days or evenings (departmental rather than Trust-wide), discounts for members in local shops and restaurants etc – to establish a package that makes Foundation Trust membership attractive.

Communications Sub-Committee to advise on the best ways to promote membership.

Matt Akid
Head of Communications
10th November 2006

Monitor

Independent Regulator
of NHS Foundation Trusts

The NHS Foundation Trust Code of Governance

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The NHS Foundation Trust Code of Governance

1 Foreword

The NHS Foundation Trust Code of Governance

Effective corporate governance is a fundamental cornerstone for the success of every NHS foundation trust. The new autonomy that foundation trusts enjoy, their public service purpose, and the fact that NHS foundation trusts are entrusted with public funds demand that their boards operate according to the highest corporate governance standards. Therefore it is essential that directors and governors of NHS foundation trusts understand clearly the key principles of good governance and how to apply them.

Our approach has been to bring best practice from the private sector to the NHS foundation trust sector. *The NHS Foundation Trust Code of Governance* (the code) has been based on the *Combined Code of Corporate Governance,* which is the closest equivalent from the private sector, and has been developed following extensive consultation.

Key aspects that have been emphasised in the code are:

- the unitary nature of the board of directors and the collective responsibility for all aspects of the performance of the foundation trust, including financial performance, clinical and service quality, management and governance;
- a recommendation for at least 50% of board members to be independent non-executive directors;
- a recommendation to appoint a senior independent director;
- an emphasis on actively addressing the quality of the board of directors through performance evaluation of the board, its committees and individual directors;
- clarification on the committee structure of the board of directors and the roles of the remuneration, audit and nomination committees. This includes a recommendation for a clear nominations process;
- clarification of the need for good quality information tailored to the board's duties and availability of access to external advice;
- a recommendation to appoint a secretary of the board of directors and the board of governors; and
- recommendations to be clear on the purpose and outcomes of the relationships of the NHS foundation trust with other stakeholders including members, patients, the local community and other NHS and non-NHS bodies with an interest in the local health economy.

I hope that you find this document is a useful tool to help you develop your corporate governance.

Dr William Moyes
Executive Chairman

2 Introduction

2.1 Why a code of governance for NHS foundation trusts?

NHS foundation trusts were created as new legal entities in the form of public benefit corporations by the Health and Social Care (Community Health and Standards) Act 2003 (the 2003 Act). The legislation constituted NHS foundation trusts with a new governance regime that is fundamentally different from NHS trusts. NHS foundation trust boards of directors now have more autonomy to make financial and strategic decisions. They also have a framework of local accountability through members and a board of governors, which has replaced central control from the Secretary of State for Health.

In this new regime, NHS foundation trust directors are ultimately and collectively responsible for all aspects of the performance of the foundation trust. Therefore, NHS foundation trust directors need to be able to deliver more focused strategic leadership and more effective scrutiny of the trust's operations. The need for further guidance on how to make this transition successfully was clear from the results of the survey of foundation trust directors and the feedback from the *Building Effective Foundation Trust Boards* conferences organised by the Foundation Trust Network and Monitor in the spring of 2005.

The purpose of this code of governance is to assist NHS foundation trust boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance. The code sets out a common overarching framework for the corporate governance of NHS foundation trusts and complements the statutory and regulatory obligations on them.

2.2 About this code

The NHS Foundation Trust Code of Governance builds on the principles and provisions of the *Combined Code of Corporate Governance* (the combined code). The combined code is well established as the prime standard of corporate governance best practice for the private sector in the UK. The combined code is the product of multiple corporate governance development efforts in the UK over many years and it encompasses recommendations from the following governance reviews:

- *The Cadbury Report* (1992) – established the basis of UK corporate governance;
- *The Greenbury Report* (1995) – focused on director remuneration and the role of the remuneration committee, and recommended remuneration disclosures;
- *The Hampel Report* (1998) – covered multiple issues, including the composition and balance of the board and the role of directors;
- *The Turnbull Report* (1999) – concentrated on aspects of risk management; and
- *The Smith Report* (2003) and *The Higgs Report* (2003) – focused on the responsibilities of the audit committee and on the role of non-executive directors respectively, following high profile corporate governance failures in the US.

Some amendments were required to adapt the principles and provisions of the combined code to the NHS foundation trust statutory and regulatory environment and to make the code of governance consistent with the public service values of foundation trusts.

Governance in the public sector, and specifically in the NHS, is the subject of several reports, some of which might also be looked at by the reader for interest:

- *Nolan Principles* – covers in detail the standards of behaviour and principles in public life with particular focus on appointment on merit, with an independent element on all selection panels recommended as the way forward for public bodies;
- *The Intelligent Board* (2006) – looks at board level information needs; and
- *The Integrated Governance Handbook* (2006) – looks in detail at the processes and information requirements of sound governance.

3 Application of *The NHS Foundation Trust Code of Governance*

1 Monitor is issuing this code as best practice advice. It is not mandatory guidance and accordingly, non-compliance with the provisions of the code will not give rise to a breach of condition 5(2) of the terms of authorisation. Notwithstanding this, the code imposes some disclosure requirements upon NHS foundation trusts and these are set out below. Further, NHS foundation trusts are strongly encouraged to take full account of the best practice provisions described in this code.

2 The code is intended to apply for the reporting years beginning on or after April 2006. The 2006-2007 annual report is the first opportunity for disclosure and all NHS foundation trusts should aim to report on their governance arrangements in that report. NHS foundation trusts will be expected to observe in full the disclosure requirements by the end of the 2007-08 financial year. Monitor will conduct a review of the process in 2008 after the first full year of applying the code.

3 The code contains main and supporting principles and provisions. The UK Listing Authority requires listed companies to make a disclosure statement in two parts in relation to the combined code. Monitor requires the same of NHS foundation trusts:

a. in the first part of the statement, the trust has to report on how it applies the main and supporting principles of the code. The form and content of this part of the statement are not prescribed, the intention being that trusts should have a free hand to explain their governance policies in the light of the principles, including any special circumstances applying to them which have led to a particular approach;
b. in the second part of the statement the trust has either to confirm that it complies with the provisions of the code or – where it does not – to provide an explanation.

This 'comply or explain' approach has been in operation for more than ten years in the private sector and the flexibility it offers companies has been widely welcomed by boards.

4 While it is expected that NHS foundation trusts will comply with the code's provisions, it is recognised that departure from the provisions of the code may be justified in particular circumstances. Every trust should review each provision carefully and give a considered explanation if it departs from it.

5 Some trusts may decide that the provisions are disproportionate or less relevant in their case. Such trusts may nonetheless consider that it would be appropriate to adopt the approach in the code and they are encouraged to consider this.

6 Whilst recognising that governors are appointed and elected by members to whom the NHS foundation trust is accountable, it is important that those concerned with the evaluation of governance should do so with common sense in order to promote partnership and trust, based on mutual understanding.

7 Schedule 1 to the 2003 Act sets out the various powers of and obligations upon governors of NHS foundation trusts. This code does not provide prescriptive guidance on the extent and interpretation of these powers and obligations. However, Monitor has described in section B of this code those areas of the governors' role that NHS foundation trusts might see as relevant and might find helpful. Monitor will look at the role of governors in 2007 and will at that stage issue further best practice advice on the governors' role, if this is thought to be necessary.

8 Monitor will continue to oversee the effectiveness and applicability of the code and develop it, in consultation with NHS foundation trusts, as governance best practice in those trusts evolves.

9 Each NHS foundation trust should consider its requirements for a trust secretary individually, but taking into account the benefits of such a role as described in appendix A of this code.

10 The code includes references to other Monitor publications on internal control:
- *NHS Foundation Trust Financial Reporting Manual*;
- *NHS Foundation Trust Accounting Officer Memorandum*;
- on audit: *Audit Code for NHS Foundation Trusts* and the *Guide for Governors: Audit Code for NHS Foundation Trusts*.

For reasons of clarity and consistency, *The NHS Foundation Trust Code of Governance* overlaps with existing statutory and regulatory documents such as some aspects of the *NHS Foundation Trust Model Core Constitution* and the annual and in-year reporting requirements of the *Compliance Framework*.

A. Directors

A.1 The board of directors

Main principle

Every NHS foundation trust should be headed by an effective board of directors, since the board is collectively responsible for the exercise of the powers and the performance of the NHS foundation trust.

Supporting principles

- The board of directors' role is to provide active leadership of the NHS foundation trust within a framework of prudent and effective controls which enables risk to be assessed and managed.
- The board of directors is responsible for ensuring compliance by the NHS foundation trust with its terms of authorisation, its constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations.
- The board of directors should set the NHS foundation trust's strategic aims, taking into consideration the views of the board of governors, ensuring that the necessary financial and human resources are in place for the NHS foundation trust to meet its objectives and review management performance.
- The board of directors as a whole is responsible for ensuring the quality and safety of healthcare services, education, training and research delivered by the NHS foundation trust and applying the principles and standards of clinical governance set out by the Department of Health, the Healthcare Commission, and other relevant NHS bodies. The board of directors should also ensure that the NHS foundation trust exercises its functions effectively, efficiently and economically.
- The board of directors should set the NHS foundation trust's values and standards of conduct and ensure that its obligations to its members, patients and other stakeholders are understood and met.
- All directors must take decisions objectively in the interests of the NHS foundation trust.
- All directors have joint responsibility for every decision of the board of directors regardless of their individual skills or status. This does not impact upon the particular responsibilities of the chief executive as the accounting officer. The chief executive should refer to guidance from Monitor on the responsibilities and obligations of the accounting officer (*NHS Foundation Trust Accounting Officer Memorandum*, April 2005).
- The concept of the unitary board refers to the fact that within the board of directors the non-executive directors and the executive directors share the same liability, as per the main principle. All directors, executive and non-executive, have responsibility to constructively challenge the decisions of the board and help develop proposals on strategy.
- As part of their role as members of a unitary board, non-executive directors have a particular duty to ensure such challenge is made. Non-executive directors should scrutinise the performance of the management in meeting agreed goals and objectives and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and that financial and clinical quality controls and systems of risk management are robust and defensible. They are responsible for determining appropriate levels of remuneration of executive directors and have a prime role in appointing, and where necessary removing, executive directors, and in succession planning.

Code provisions

A.1.1 The board of directors should meet sufficiently regularly to discharge its duties effectively. There should be a formal schedule of matters specifically reserved for decision by the board of directors. The schedule of matters reserved for the board of directors should be complemented with a clear statement detailing the roles and responsibilities of the board of governors (as described in B.1.4). There should also be a statement explaining how disagreements between the board of governors and the board of directors will be resolved. The annual report should include a statement of how the board of directors and the board of governors operate, including a high-level statement of which types of decisions are to be taken by each of the boards and which decisions are to be delegated to the management by the board of directors. The developmental nature of the board of governors' role would suggest that any agreements should be kept under review as the role evolves.

A.1.2 The annual report should identify the chairman, the deputy chairman (where there is one), the chief executive, the senior independent director (see A.3.3) and the chairmen and members of the nomination, audit and remuneration committees. A record should be kept of the number of meetings of the board of directors and the attendance of individual directors, and it should be supplied to the board of governors on request.

A.1.3 The chairman should hold meetings with the non-executive directors without the executives present. Led by the senior independent director, the non-executive directors should meet without the chairman at least annually to evaluate the chairman's performance, as part of a process, which should be agreed with the board of governors, for appraising the chair and on such other occasions as are deemed appropriate.

A.1.4 The board of directors should make available[1] a statement of the objectives of the NHS foundation trust showing how it intends to balance the interests of patients, the local community and other stakeholders, and use this as the basis for its decision making and forward planning.

A.1.5 The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery. The board should regularly review the performance of the NHS foundation trust in these areas against regulatory requirements and approved plans and objectives.

1 This would be achieved by making the information available on request and by including it on the NHS foundation trust's website.

A.1.6 The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in accordance with guidance set out by the Department of Health, the Healthcare Commission and Monitor.

A.1.7 Where directors have concerns, which cannot be resolved, about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes.

A.1.8 The chief executive, as the accounting officer, should follow the procedure set out by Monitor (*NHS Foundation Trust Accounting Officer Memorandum*, April 2005) for advising the board of directors and the board of governors, and for recording and submitting objections to decisions considered or taken by the boards in matters of propriety or regularity, and on issues relating to the wider responsibilities of the accounting officer for economy, efficiency and effectiveness.

A.1.9 The board of directors should establish the values and standards of conduct for the NHS foundation trust and its staff 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).

A.1.10 The board of directors should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility. The board of directors should follow a policy of openness and transparency in its proceedings and decision making unless this conflicts with a need to protect the wider interests of the public or the NHS foundation trust (including commercial-in-confidence matters) and make clear how potential conflicts of interests are dealt with.

A.1.11 The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors.

A.2 Chairman and chief executive

Main principle

There should be a clear division of responsibilities at the head of the NHS foundation trust between the chairing of the boards of directors and governors and the executive responsibility for the running of the NHS foundation trust's business. No one individual should have unfettered powers of decision.

Supporting principles

- The chairman is responsible for leadership of the board of directors and the board of governors, ensuring their effectiveness on all aspects of their role and setting their agenda.
- The chairman is responsible for ensuring that the two boards work together effectively.
- The chairman is also responsible for ensuring that directors and governors receive accurate, timely and clear information that is appropriate for their respective duties.
- The chairman should ensure effective communication with patients, members, clients, staff and other stakeholders.
- The chairman should also facilitate the effective contribution of all executive and non-executive directors and ensure that constructive relations exist between executive and non-executive directors, and between the board of directors and the board of governors.

Code provisions

A.2.1 The division of responsibilities between the chairman and chief executive should be clearly established, set out in writing and agreed by the board.

A.2.2 The chairman should on appointment meet the independence criteria set out in A.3.1 below. A chief executive should not go on to be chairman of the same NHS foundation trust.

A.3 Balance and independence of the board of directors

Main principle

The board of directors should include a balance of executive and non-executive directors (and in particular independent non-executive directors) such that no individual or small group of individuals can dominate the board's decision taking.

All directors should be able to exercise one full vote, with the chairman having a second casting vote on those occasions where a decision is tied.

Supporting principles

- The board of directors should not be so large as to be unwieldy. The board should be of sufficient size that the balance of skills and experience is appropriate for the requirements of the business and that changes to the board's composition can be managed without undue disruption.
- To ensure that power and information are not concentrated in one or two individuals, there should be a strong presence on the board of both executive and non-executive directors.
- The value of ensuring that committee membership is refreshed and that undue reliance is not placed on particular individuals should be taken into account in deciding chairmanship and membership of committees.
- Only the committee chairman and relevant members are entitled to be present at a meeting of the nomination, audit or remuneration committees, but others may attend by invitation of the committee.

Code provisions

A.3.1 The board of directors should identify in the annual report each non-executive director it considers to be independent.[2] The board should determine whether the director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement. The board should state its reasons if it determines that a director is independent notwithstanding the existence of relationships or circumstances which may appear relevant to its determination, including if the director:

- has been an employee of the NHS foundation trust within the last five years;
- has, or has had within the last three years, a material business relationship with the NHS foundation trust either directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the NHS foundation trust;
- has received or receives additional remuneration from the NHS foundation trust apart from a director's fee, participates in the NHS foundation trust's performance-related pay scheme, or is a member of the NHS foundation trust's pension scheme;
- has close family ties with any of the NHS foundation trust's advisers, directors or senior employees;
- holds cross-directorships or has significant links with other directors through involvement in other companies or bodies;
- has served on the board for more than nine years from the date of their first election;
- is an appointed representative of the NHS foundation trust's university medical or dental school.

2 A.2.2 states that the chairman should, on appointment, meet the independence criteria set out in this provision, but thereafter the test of independence is not appropriate in relation to the chairman.

A.3.2 At least half the board, excluding the chairman, should comprise non-executive directors determined by the board to be independent.

A.3.3 The board of directors should appoint one of the independent non-executive directors to be the senior independent director, in consultation with the board of governors. The senior independent director should be available to members and governors if they have concerns which contact through the normal channels of chairman, chief executive or finance director has failed to resolve or for which such contact is inappropriate. The senior independent director could be the deputy chairman.

A.3.4 The board of directors should include in its annual report a description of each director's expertise and experience. Alongside this in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust. Both statements should also be available on the NHS foundation trust's website.

A.3.5 No individual should hold, at the same time, positions of director and governor of NHS foundation trusts.

B. Governors

Schedule 1 to the 2003 Act sets out the various powers of, and obligations upon, governors of NHS foundation trusts. This code does not provide prescriptive guidance on the extent and interpretation of these powers and obligations. However, Monitor has described in this section of the code those areas of the governor's role that are relevant and which NHS foundation trusts might find helpful.

B.1 The board of governors

Main principle

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 to account for the performance of the trust, including ensuring the board of directors acts so that the foundation trust does not breach the terms of its authorisation.

Governors are responsible for regularly feeding back information about the trust, its vision and its performance to the constituencies and the stakeholder organisations that either elected or appointed them.

Supporting principles

- Governors should discuss and agree with the board of directors how they will undertake these and any other additional roles, giving due consideration to the circumstances of the NHS foundation trust and the needs of the local community and emerging best practice.
- Governors should work closely with the board of directors and must be presented with, for consideration, the annual report and accounts and the annual plan at a general meeting. The governors can expect to be consulted on the development of forward plans for the trust and any significant changes to the delivery of the trust's business plan.

Code provisions

B.1.1 The board of governors should meet sufficiently regularly to discharge its duties effectively. Governors should make every effort to attend the meetings of the board of governors where practicable. The NHS foundation trust should facilitate this.

B.1.2 The board of governors should not be so large as to be unwieldy. The board of governors should be of sufficient size for the requirements of its duties. The roles, structure, composition, and procedures of the board of governors should be reviewed regularly as described in provision D.2.2.

B.1.3 The annual report should identify the members of the board of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. A record should be kept of the number of meetings of the board and the attendance of individual governors and it should be made available to members on request.

B.1.4 The roles and responsibilities of the board of governors should be set out in a written document. This statement should include a clear explanation of the responsibilities of the board of governors towards members and other stakeholders and how governors will seek their views and inform them.

B.1.5 The board of governors should receive and consider other appropriate information required to enable it to discharge its duties, for example, clinical and operational data.

B.1.6 The chairman is responsible for leadership of both boards (A.2) but the governors themselves have a responsibility to make the arrangements work and should take the lead in inviting the chief executive to their meetings and inviting attendance by other executives and non-executives as appropriate. In these meetings other board members may raise questions of the chairman or his deputy or any other director present at the meeting about the affairs of the NHS foundation trust.

B.1.7 The board of governors should establish a policy for engagement with the board of directors for those circumstances when they have concerns about the performance of the board of directors, compliance with the terms of authorisation or the welfare of the NHS foundation trust. The board of governors should consider the advantages of there being a senior independent director on the board of directors (see A.3.3).

B.1.8 The board of governors should inform Monitor if the trust is at risk of breaching the terms of its authorisation if these concerns cannot be resolved at a local level. Governors should acknowledge the overall responsibility of the board of directors for running the NHS foundation trust and should not try to use the powers of the board of governors to veto the decisions of the board of directors. The board of governors should only exercise its power to remove the chairman or any non-executive directors after exhausting all other means of engagement with the board of directors.

C. Appointments and terms of office

C.1 Appointments to the boards

Main principle

The 2003 Act presents how appointments to the board are to be made. There should be a formal, rigorous and transparent procedure for the appointment or election of new members to the boards of directors.

Appointments to the board of directors should be made on merit and based on objective criteria.

Care should be taken to ensure that appointees have enough time available to devote to the job. This is particularly important in the case of chairmanships.

The board of directors should satisfy itself that plans are in place for orderly succession of appointments to the board so as to maintain an appropriate balance of skills and experience within the NHS foundation trust and on the board.

Code provisions

C.1.1 A nominations committee should regularly review the structure, size and composition of the board of directors and make recommendations for changes where appropriate. The nominations committee should give full consideration to succession planning, taking into account the challenges and opportunities facing the NHS foundation trust and the skills and expertise required on the board.

C.1.2 There should be a nomination process for the identification and nominations of executive and non-executive directors. There may be one nominations committee responsible for the identification and nomination of executive and non-executive directors or two nominations committees. If there are two, one would be responsible for the nomination of executive directors and the other for identification and nomination of non-executive directors. The nomination committee(s) should evaluate the balance of skills, knowledge and experience on the board and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment of both executive and non-executive directors, including the chairman.

C.1.3 The chairman or an independent non-executive director should chair the committee(s).

C.1.4 The governors are responsible at a general meeting for the appointment, re-appointment and removal of the chair and the other non-executive directors. They should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified the nominations committee should make recommendations to the board of governors.

C.1.5 When considering the appointment of non-executive directors, the board of governors should take into account the views of the board of directors on the qualifications, skills and experience required for each position.

C.1.6 For the appointment of a chairman, the nomination committee should prepare a job specification defining the role and capabilities required including an assessment of the time commitment expected, recognising the need for availability in the event of emergencies. A chairman's other significant commitments should be disclosed to the board of governors before appointment and included in the annual report. Changes to such commitments should be reported to the board of governors as they arise, and included in the next annual report. No individual, simultaneously with being a chairman of an NHS foundation trust, should be the chairman of another NHS foundation trust.

C.1.7 The terms and conditions of appointment of non-executive directors should be made available for inspection. The letter of appointment should set out the expected time commitment. Non-executive directors should undertake that they will have sufficient time to meet what is expected of them. Their other significant commitments should be disclosed to the board of governors before appointment, with a broad indication of the time involved and the board of governors should be informed of subsequent changes.

C.1.8 The annual report should describe the process followed by the board of governors in relation to appointments of the chairman and non-executive directors.

C.1.9 It is a requirement of the 2003 Act that the chairman, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive, are responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the chairman, the other non-executives directors and, except in the case of the appointment of a chief executive, the chief executive.

C.1.10 It is for the non-executive directors to appoint and remove the chief executive. The appointment of a chief executive requires the approval of the board of governors.

C.1.11 The board of directors should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity, nor the chairmanship of such an organisation.

C.1.12 A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.

C.2 Re-election

Main principle

All directors and elected governors should be submitted for re-appointment or re-election at regular intervals. The board of directors should ensure planned and progressive refreshing of the board of directors.

Code provisions

C.2.1 Approval by the board of governors of the appointment of a chief executive should be a subject of the first general meeting after the appointment by a committee of the chairman and non-executive directors. 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. All other executive directors should be appointed by a committee of the chief executive, the chairman and non-executive directors and subject to re-appointment at intervals of no more than five years.

C.2.2 Non-executive directors, including the chairman, should be appointed by the board of governors for specified terms subject to re-appointment thereafter at intervals of no more than three years and to the 2003 Act provisions relating to the removal of a director. The chairman should confirm to governors that, following formal performance evaluation, the performance of the individual proposed for re-election continues to be effective and to demonstrate commitment to the role. Any term beyond six years (e.g. two three-year terms) for a non-executive director should be subject to particularly rigorous review, and should take into account the need for progressive refreshing of the board. Non-executive directors may serve longer than nine years (e.g. three three-year terms), subject to annual re-election. Serving more than nine years could be relevant to the determination of a non-executive director's independence (as set out in provision A.3.1).

C.2.3 Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to take an informed decision on their election. This should include prior performance information such as attendance record at governor meetings and other relevant events organised by the NHS foundation trust for governors.

D. Information, development and evaluation

D.1 Information and professional development

Main principle

The board of directors and the board of governors should be supplied in a timely manner with information in a form and of a quality appropriate to enable them to discharge their respective duties.

All directors and governors should receive induction on joining their boards and should regularly update and refresh their skills and knowledge.

Supporting principles

- The chairman is responsible for ensuring that the directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and governors should seek clarification or amplification where necessary.
- The chairman should ensure that the directors and governors continually update their skills, knowledge and familiarity with the NHS foundation trust, to fulfil their role both on the board and on board committees. The NHS foundation trust should provide the necessary resources for developing and updating its directors' and governors' knowledge and capabilities.
- The responsibilities of the chairman include ensuring good information flows in the boards and their committees, between directors and governors, and between senior management and non-executive directors, as well as facilitating induction and assisting with professional development as required.

Code provisions

D.1.1 The chairman should ensure that new directors and governors receive a full, formal and tailored induction on joining the board.

D.1.2 The board should ensure that directors, especially non-executive directors, have access to independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors. Directors should also have access, at the NHS foundation trust's expense, to training courses and/or materials that are consistent with their individual and collective development programme as described in provision D.2. Decisions to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.

Committees should be provided with sufficient resources to undertake their duties. The board of directors should also ensure that the board of governors is provided with sufficient resources to undertake its duties, with such arrangements agreed in advance.

Non-executives need not seek to appoint a relevant adviser for each and every subject area that comes before the board. When difficult issues arise the first course of action should always be to encourage further and deeper analysis to be carried out within the NHS foundation trust.

D.1.3 The board of directors and the board of governors should be provided with high quality information appropriate to the respective functions of the boards and relevant to the decisions they have to make. The board of directors and the board of governors should agree their respective information needs with the executive directors. The information for the boards should be concise, objective, accurate and timely, and it should be accompanied by clear explanations of complex issues. The board of directors should have complete access to any information about the NHS foundation trust that it deems necessary to discharge its duties, including access to senior management and other employees.

D.2 Performance evaluation

Main principles

The board of directors should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors.

The board should state in the annual report how performance evaluation of the board, its committees and its individual directors including the chairman, has been conducted, bearing in mind the desirability for independent assessment, and the reason why the NHS foundation trust adopted a particular method of performance evaluation.

The outcomes of the evaluation of the executive directors should be reported to the board of directors. The chief executive should take the lead on the evaluation of the executive directors.

The board of governors which is responsible for the appointment and re-appointment of non-executive directors, should take the lead on agreeing a process for the evaluation of the chair and the non-executives, with the chairman and the non-executives. The outcomes of the evaluation of the chairman and the non-executive directors should be agreed by governors. The governors should bear in mind the desirability of using the senior independent director to lead the non-executive directors in the evaluation of the chairman.

The board of governors should assess its own collective performance and its impact in the NHS foundation trust.

Supporting principles

- Individual evaluation of directors should aim to show whether each director continues to contribute effectively and to demonstrate commitment to the role (including commitment of time for board and committee meetings and any other duties). The chairman should act on the results of the performance evaluation by recognising the strengths and addressing the weaknesses of the board, identifying individual and collective development needs and, where appropriate, proposing new members be appointed to the board or seeking the resignation of directors.

Code provisions

D.2.1 The chairman, with the assistance of the secretary of the boards if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for directors relevant to their duties as board members.

D.2.2 Led by the chairman, the board of governors should periodically assess their collective performance and they should regularly communicate to members details on how they have discharged their responsibilities, including their impact and effectiveness on:

- advising the board on the forward plans of the NHS foundation trust; and
- communicating with their member constituencies and transmitting their views to the board of directors.

The board of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice.

D.2.3 There should be a clear policy and a fair process for the removal from the board of any governor that consistently and unjustifiably fails to attend the meetings of the board of governors, has a conflict of interest that makes them incompatible with the values and behaviours of the NHS foundation trust or fails to discharge their other responsibilities as a governor.

E. Director remuneration

E.1 The level and make-up of remuneration

Main principle

Levels of remuneration should be sufficient to attract, retain and motivate directors of the quality required to run the NHS foundation trust successfully, but an NHS foundation trust should avoid paying more than is necessary for this purpose.

Supporting principles

- The remuneration committee should decide if a proportion of executive directors' remuneration should be structured so as to link reward to corporate and individual performance. The remuneration committee should judge where to position its NHS foundation trust relative to other NHS foundation trusts and comparable organisations. Such comparisons, however, should be used with caution in view of the risk of an upward ratchet of remuneration levels with no corresponding improvement in performance.
- The remuneration committee should also be sensitive to pay and employment conditions elsewhere in the NHS foundation trust, especially when determining annual salary increases.

Code provisions

Remuneration policy

E.1.1 Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should follow the following provisions:

(i) The remuneration committee should consider whether the directors should be eligible for annual bonuses. If so, performance conditions should be relevant, stretching and designed to match the long term interests of the public. Upper limits should be set and disclosed.

(ii) Payouts or grants under all incentive schemes, should be subject to challenging performance criteria reflecting the objectives of the NHS foundation trust. Consideration should be given to criteria which reflect the performance of the NHS foundation trust relative to a group of comparator trusts in some key indicators.

(iii) In general, only basic salary should be pensionable.

(iv) The remuneration committee should consider the pension consequences and associated costs to the NHS foundation trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.

E.1.2 Levels of remuneration for the chairman and other non-executive directors should reflect the time commitment and responsibilities of their roles.

E.1.3 Where an NHS foundation trust releases an executive director to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement on whether or not the director will retain such earnings.

Service contracts and compensation

E.1.4 The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointment would entail in the event of early termination. The aim should be to avoid rewarding poor performance. They should take a robust line on reducing compensation to reflect departing directors' obligations to mitigate loss.

E.2 Procedure

Main principle

There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration.

Supporting principles

- The remuneration committee should consult the chairman and/or chief executive about its proposals relating to the remuneration of other executive directors.
- The remuneration committee should also be responsible for appointing any independent consultants in respect of executive director remuneration.
- Where executive directors or senior management are involved in advising or supporting the remuneration committee, care should be taken to recognise and avoid conflicts of interest.

Code provisions

E.2.1 The board of directors must establish a remuneration committee composed of non-executive directors which should include at least three independent non-executive directors. The remuneration committee should make available its terms of reference, explaining its role and the authority delegated to it by the board of directors. Where remuneration consultants are appointed, a statement should be made available of whether they have any other connection with the NHS foundation trust.

E.2.2 The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The definition of 'senior management' for this purpose should be determined by the board but should normally include the first layer of management below board level.

E.2.3 The board of governors is responsible for setting the remuneration of non-executive directors and the chair. The board of governors should consult external professional advisers to market-test the remuneration levels of the chairman and other non-executives at least once every three years and when they intend to make a large change to the remuneration of a non-executive.

F. Accountability and audit

F.1 Financial and operational reporting

Main principle

The board of directors should present a balanced and understandable assessment of the NHS foundation trust's position and prospects.

Supporting principle

- The responsibility of the board of directors to present a balanced and understandable assessment extends to all public statements and reports to regulators and inspectors, as well as information required to be presented by statutory requirements.

Code provisions

F.1.1 The directors should explain in the annual report their responsibility for preparing the accounts and there should be a statement by the auditors about their reporting responsibilities.

F.1.2 The directors should report that the NHS foundation trust is a going concern, with supporting assumptions or qualifications as necessary.

F.1.3 (a) The board of directors must notify Monitor and the board of governors without delay, and should consider whether it is in the public interest to bring to the public attention, any major new developments in the NHS foundation trust's sphere of activity which are not public knowledge which may lead, by virtue of its effect on its assets and liabilities or financial position or on the general course of its business, to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS foundation trust.

(b) The board of directors must notify Monitor and the board of governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a change:

- in the NHS foundation trust's financial condition;
- in the performance of its business; and/or
- in the NHS foundation trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS foundation trust.

F.1.4 At least annually, the board of directors should set out clearly its financial and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operations, including clinical outcome data, to allow members and governors to evaluate its performance.

F.2 Internal control

Main principle

The board should maintain a sound system of internal control to safeguard public and private investment, the NHS foundation trust's assets, patient safety and service quality.

Monitor's publications, *NHS Foundation Trust Financial Reporting Manual* and the *NHS Foundation Trust Accounting Officer Memorandum* give further guidance.

Code provision

F.2.1 The board should conduct, at least annually, a review of the effectiveness of the NHS foundation trust's system of internal control and should report to members that they have done so. The review should cover all material controls, including financial, clinical, operational and compliance controls and risk management systems.

F.3 Audit committee and auditors

Main principle

The board should establish formal and transparent arrangements for considering how they should apply the financial reporting and internal control principles and for maintaining an appropriate relationship with the NHS foundation trust's auditors.

Monitor's publications *Audit Code for NHS Foundation Trusts* and the *Guide for Governors: Audit Code for NHS Foundation Trusts* give further guidance.

Code provisions

F.3.1 The board must establish an audit committee composed of non-executive directors which should include at least three independent non-executive directors. The board should satisfy itself that at least one member of the audit committee has recent and relevant financial experience.

F.3.2 The main role and responsibilities of the audit committee should be set out in written terms of reference and should include details of how it will:

- monitor the integrity of the financial statements of the NHS foundation trust, and any formal announcements relating to the trust's financial performance, reviewing significant financial reporting judgements contained in them;
- review the NHS foundation trust's internal financial controls and, unless expressly addressed by a separate board risk committee composed of independent directors, or by the board itself, review the trust's internal control and risk management systems;
- monitor and review the effectiveness of the NHS foundation trust's internal audit function;
- review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements;
- develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm; and
- report to the board of governors, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken.

F.3.3 The terms of reference of the audit committee, including its role and the authority delegated to it by the board of directors and by the board of governors, should be made publicly available.[3] A separate section of the annual report should describe the work of the committee in discharging those responsibilities.

F.3.4 The audit committee should review arrangements by which staff of the NHS foundation trust may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The audit committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

F.3.5 The board of governors should take the lead in agreeing with the audit committee the criteria for appointing, reappointing and removing auditors.

The audit committee should make recommendations to the board of governors, in relation to the appointment, re-appointment and removal of the external auditor and approve the remuneration and terms of engagement of the external auditor.

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 should set out reasons why the board of governors has taken a different position.

F.3.6 When the board of governors ends an auditor's appointment in disputed circumstances, the chairman should write to Monitor informing it of the reasons behind the decision.

F.3.7 The annual report should explain to members how, if the auditor provides non-audit services, auditor objectivity and independence is safeguarded.

3 This would be achieved by making the information available on request and by including it on the NHS foundation trust's website.

G Relations with stakeholders

G.1 Dialogue with members, patients and the local community

Main principle

The board of directors should appropriately consult and involve members, patients, clients and the local community. Notwithstanding the complementary role of the governors in this consultation, the board of directors as a whole has responsibility for ensuring that satisfactory dialogue with its stakeholders takes place.

Supporting principles

- The board of directors should keep in touch with the opinion of members, patients, clients and the local community in whatever ways are most practical and efficient. There should be a members' meeting at least annually.
- The chairman (and the senior independent director and other directors as appropriate) should maintain sufficient contact with governors to understand their issues and concerns.

Code provisions

G.1.1 The board of directors should make available a public document that sets out its policy on the involvement of members, patients, clients and the local community at large, including a description of the kind of issues it will consult on.

G.1.2 The board of directors should clarify in writing how the public interests of patients, clients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums already in place (e.g. patients' forums, the overview and scrutiny committee, the local League of Friends, and staff groups).

G.1.3 The chairman should ensure that the views of governors and members are communicated to the board as a whole. The chairman should discuss the affairs of the NHS foundation trust with governors. Non-executive directors should be offered the opportunity to attend meetings with governors and should expect to attend them if requested by governors. The senior independent director should attend sufficient meetings with governors to listen to their views in order to help develop a balanced understanding of the issues and concerns of governors.

G.1.4 The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members that wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.

G.1.5 The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the board of governors, direct face-to-face contact, surveys of member opinion and consultations.

G.1.6 The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement. This information should be used to review the trust's membership strategy, taking into account any emerging best practice from the sector.

G.2 Co-operation with third parties with roles in relation to NHS foundation trusts

Main principle

The board of directors is responsible for ensuring that the NHS foundation trust co-operates with other NHS bodies, local authorities and other relevant organisations with an interest in the local health economy.

Supporting principle

- The board of directors should enter a dialogue with third party organisations with roles in relation to NHS foundation trusts based on the mutual understanding of objectives.

Code provisions

G.2.1 The board of directors should maintain a schedule of the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate (boards should refer to appendix E of Monitor's *Compliance Framework* for a generic, non-exhaustive list of bodies). Directors should be clear of the form and scope of the co-operation required with each of these bodies in order to discharge their statutory duties.

G.2.2 The board of directors should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative relationships are maintained with relevant stakeholder bodies at various levels as required. Periodically, the board should review the effectiveness of these processes and relationships and take steps to improve them. This might involve seeking feedback from the relevant third party bodies as appropriate and practicable.

Schedule A:
Disclosure of corporate governance arrangements

For ease of reference, the specific requirements in the code for disclosure are set out below.

The **annual report should record**:

- a statement of how the board of directors and the board of governors operate, including a high-level statement of which types of decisions are to be taken by each of the boards and which are to be delegated to management by the board of directors (A.1.1);
- the names of the chairman, the deputy chairman (where there is one), the chief executive, the senior independent director and the chairmen and members of the nomination, audit and remuneration committees (A.1.2);
- the number of meetings of the board of directors and those committees and individual attendance by directors (A.1.2);
- the names of the non-executive directors whom the board determines to be independent, with reasons where necessary (A.3.1);
- a description of each director's expertise and experience (A.3.4);
- a clear statement about the board of directors' balance, completeness and appropriateness (A.3.4);
- the names of the governors and details on their constituency, whether they are elected or appointed and the duration of their appointments (B.1.3);
- the number of meetings of the board of governors and individual attendance by governors and directors (B.1.3);
- the other significant commitments of the chairman and any changes to them during the year (C.1.6);

- a separate section describing the work of the nomination committee, including the process it has used in relation to board appointments and an explanation if neither external search consultancy nor open advertising has been used in the appointment of a chairman or a non-executive director (C.1.12);
- how performance evaluation of the board of directors, its committees and its directors has been conducted (D.2);
- as part of the remuneration disclosures of the annual report, where an executive director serves as a non-executive director elsewhere, whether or not the director will retain such earnings (E.1.3);
- an explanation from the directors of their responsibility for preparing the accounts and a statement by the auditors about their reporting responsibilities (F.1.1);
- a statement from the directors that the business is a going concern, with supporting assumptions or qualifications as necessary (F.1.2);
- a report that the board has conducted a review of the effectiveness of the group's system of internal controls (F.2.1);
- a separate section describing the work of the audit committee in discharging its responsibilities (F.3.3);
- where the board of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, a statement from the audit committee explaining the recommendation and the reasons why the board of governors has taken a different position (F.3.5);
- an explanation of how, if the auditor provides non-audit services, auditor objectivity and independence is safeguarded (F.3.7);
- contact procedures for members that wish to communicate with governors and/or directors (G.1.4); and
- the steps the board has taken to ensure that members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about their NHS foundation trust (G.1.5).

The **following information should be made** available (which may be met by making it available on request and making the information available on the NHS foundation trust's website):

- a statement of the objectives of the NHS foundation trust and an explanation of how interests of patients, the local community and other stakeholders will be balanced (A.1.4);
- the terms of reference of the nomination, remuneration and audit committees, explaining their role and the authority delegated to them by the boards (E.2.1 and F.3.3);
- a description of each director's expertise and experience (A.3.4);
- a clear statement about the board of directors' balance, completeness and appropriateness (A.3.4);
- the terms and conditions of appointment of non-executive directors (C.1.7);
- where remuneration consultants are appointed, a statement of whether they have any other connection with the NHS foundation trust (E.2.1);
- the policy on the involvement of members, patients and the local community at large, including a description of the kind of issues on which they will be consulted (G.1.1); and
- contact procedures for members that wish to communicate with governors and/or directors (G.1.4).

The **board should set out to governors** in the papers accompanying a resolution to re-appoint a non-executive director:

- confirmation from the chairman that, following formal performance evaluation, the individual's performance continues to be effective and to demonstrate commitment to the role, including commitment of time for board and committee meetings and any other duties (C.2.2).

The **board should set out to members** in the papers accompanying a resolution to elect or re-elect a governor:

- sufficient biographical details and other relevant information, including any prior performance information, to enable members to take an informed decision on their election or re-election of governors (C.2.3).

Appendix A: The role of the NHS foundation trust secretary

The NHS foundation trust secretary has a significant role to play in the administration of corporate governance. In particular, the trust secretary would normally be expected to:

- ensure good information flows within the board and its committees and between senior management, non-executive directors and governors;
- ensure that board procedures of both the board of directors and the board of governors are complied with;
- advise the board of directors and the board of governors (through the chairman) on all governance matters; and
- be available to give advice and support to individual directors, particularly in relation to the induction of new directors and assistance with professional development.

Accordingly, the NHS foundation trust should give careful consideration to the appointment of a trust secretary in view of the clear benefits of the role. A trust secretary is normally employed by the NHS foundation trust. All directors and governors would have access to the advice and services of the trust secretary. Both the appointment and removal of the trust secretary would be a matter for the chief executive and chairman jointly.

Monitor

Independent Regulator
of NHS Foundation Trusts

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Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 23rd November 2006

AGENDA ITEM NO.	3.3/Nov/06
PAPER	Roles and Responsibilities of the Members' Council
AUTHOR	Fleur Hansen, Foundation Trust Lead
LEAD	Juggy Pandit, Chair
SUMMARY	This paper details the Roles and Responsibilities of the Members' Council as circulated previously. These are being circulated again to remind the Council of their role and to discuss any amendments deemed appropriate.
DECISION/ ACTION	The Members' Council is asked to note their Roles and Responsibilities and discuss if necessary.

What is the role of a Members Councillor?

The Members' Council is made up of patients, public, staff and our partners in the NHS, local authorities and universities. A driving force behind NHS Foundation Trusts is the active participation of local people, patients and staff. A crucial role of the Members' Council will be to engage with the hospital membership as well as with the broader communities which the hospital serves.

Some of the key roles of a council member will be to:

- provide views to the Board of Directors on future plans for the hospital and services
- respond to the Board of Directors on specific issues
- decide the remuneration, allowances and other terms and conditions of office of the Non Executive Directors
- serve the interests of the community they represent
- appoint the Chair, other Non-Executive Directors and Financial Auditor
- approve the appointment (by the Non-Executive Directors) of any new Chief Executive
- review the Trust's constitution
- Develop and review the Trust's membership and communication strategy.

Roles and responsibilities of the Members' Council in relation to the Trust Board of Directors

The Members' Council **will** be responsible for representing the interests of the local community in the management and stewardship of the Trust, and for sharing information about key decisions with other NHS Foundation Trust members. The Members' Council will **not** be responsible for the day to day management of the organisation – e.g. setting budgets, staff pay and other operational matters – which remain a matter for the Board of Directors.

The Members will enable local residents, staff and key stakeholders to influence decisions about spending and the development of services and the Members' Council will also appoint the chair and non-executive directors of the Board of Directors.

Governance arrangements for each Foundation Trust will ultimately be tailored to the individual circumstances of each Trust, reflecting the range of diverse relationships with patients, the local community and other stakeholders.

Council Members should get involved in Influencing policy and strategy – for example, in developing the annual forward plan for Monitor and in Membership recruitment and development

The role of the Members' Council in seeking the views of patients and the public

Council Members can bring a community perspective to solving issues and inform service changes by engaging with the broader membership, which will encompass the views of patients, staff and members of the public.

There are many ways in which the Members' Council can work with the membership – for example, Council Member-led community surgeries and member focus groups on local priorities; open days and seminars (like the Hand Hygiene Awareness Week event) and involving more members in the Chelwest Readers' Group on Patient Information.

Work is also underway to involve the Membership in the production of this year's Chelsea and Westminster Hospital NHS Foundation Trust annual report as well as seeking their views on the 2005/06 annual report.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 23rd November 2006

AGENDA ITEM NO.	3.4/Nov/06
PAPER	Finance Report – September 2006
AUTHOR	Lorraine Bewes, Director of Finance and Information
LEAD	Lorraine Bewes, Director of Finance and Information
SUMMARY	This report presents the information on the Trust's finances to the end of September 2006.
DECISION/ ACTION	The Council is asked to note this report.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

CONFIDENTIAL
Board of Directors Meeting, 2nd November 2006

AGENDA ITEM NO.	2.1/Nov/06
PAPER	Finance Report – September 2006
AUTHOR	Jon Bell, Deputy Director of Finance
LEAD	Lorraine Bewes, Director of Finance and Information
EXECUTIVE SUMMARY	The year to the end of September 2006 represents the end of the period as an NHS Trust prior to authorisation as a Foundation Trust on the 1st October. The Trust will continue to monitor and report performance against the full year target however, the Trust will prepare two sets of accounts, one for six months to 30th September 2006 (for consolidation into the NHS accounts) and one for the six months to 31st March 2007 as a Foundation Trust. This report summarises the unaudited position for the six months to 30th September 2006.
DECISION/ ACTION	The Board is asked to note the financial position at Month 6.

Financial Summary to September 2006

1.0 Income and Expenditure

1.1 The YTD financial position for the Trust is an I&E surplus of £0.450m which is an improvement of £0.519m on the I&E position reported at Month 5. The year end forecast as at Month 6 is to achieve an I&E surplus of £1.5m which is in line with the FT Plan submitted.

	Year to 30th September 06				Forecast			
	Budget £'m	Actual £'m	Variance £'m	% Var	Budget £'m	Actual £'m	Variance £'m	%Var
Income	117.6	116.7	-0.9	-0.8%	237.8	236.6	-1.2	-0.0
Expenditure	108.2	107.5	0.7	0.6%	219.7	218.2	1.5	0.0
EBITDA	9.4	9.2	-0.2		18.1	18.4	0.3	
EDITDA Margin	8.0%	7.9%			7.6%	7.8%		
Interest, Dividends and Depreciation	9.0	8.8	0.2		16.6	16.9	-0.3	
Surplus/Deficit (-ve)	0.4	0.4	0.0		1.5	1.5	-0.0	

1.2 Key highlights in the Income and Expenditure position are:

a) The Trust is reporting an I&E surplus of £0.450m for the six months to 30th September 2006 and is forecasting a year end I&E surplus of £1.5m.

b) The movement between the YTD and forecast position is the accounting gain resulting from increasing the life of the building from the District Valuer's assessment to the life assessed by an Independent Valuer. This reduces the depreciation for the second half of the year by £1.1m.

c) The HIV income risk reported last month has now been satisfactorily resolved with a net loss of income to the Trust of £0.2m. The profile of HIV drugs spend is weighted towards the second half of the year and therefore £1.5m of HIV income has been deferred into the second six months of the year to cover this cost.

d) The deterioration of £0.444m in the year to date SaFF income position is in line with the income forecast last month and is due to raising the credit notes against Q1 data validations and providing for further Q2 validations. Both of these transactions were previously reflected in the forecast only.

e) The Central non-Saff income has deteriorated by £0.326m in the month to a YTD deficit of £0.822m. This is due to reflecting the expected loss on MFF corresponding to the underperformance on SaFF and HIV income within the year-to-date position.

f) The forecast income position assumes a loss of £0.36m due to reduced non-urgent activity from K&C in the last quarter. There is no impact in the six months to September 2006.

g) The full MPET income loss of £1.1m has been assumed in the forecast with half taken into the Month 6 position. This has been absorbed non-recurrently by the release of NHS provisions no longer required and uncommitted developments pending work up of recurrent mitigating savings.

h) Front-line directorates have improved by £0.292m in month however, there were overspends in Surgery, A&I and W&C mitigated by underspends in HIV/GUM and Medicine. The improvement in Medicine is in line with the expected forecast and relates to the additional funding for Endoscopy non-pay previously held in reserves.

i) A review of all reserves at Month 6 has resulted in further non-recurrent slippage on planned expenditure set aside in reserves. This has been offset by an increase in the provisions against overseas visitors and private patient debt.

2.0 Savings Plans

2.1 Progress on savings plans is unchanged from Month 5 with year to date achievement running 7% behind plan. The total savings target for the year was £11.073m and schemes have been identified for the full amount. A further £1.1m recurrent savings is required to mitigate the loss on MPET funding, however for 2006/07 this loss will be mitigated non-recurrently through slippage on developments and release of provisions no longer required.

3.0 Risks

3.1 The main risks to achieving the current forecast out-turn relate to the risks within the savings plans. The highest risk saving plan in the forecast relates to the savings expected from the Nurse Rostering implementation which is expected to deliver £0.592m savings in 2006/07. It should be noted that significant progress has been made in implementing the rostering system across all wards in a very short timescale and the system is already providing useful management information which will help to drive the efficiencies planned.

4.0 Cash Position

4.1 The cash position at the end of September was a balance of £0.482m, down from a balance of £10.649m at the end of August. This is due to paying the half yearly dividend of £4.833m in September and repaying PDC of £6.635m which mainly related to cash brokerage. The cash brokerage was converted to a loan of £6.25m and drawn down in October. The year end forecast of a £11.7m positive cash balance is unchanged from last month. The drawdown of PDC and loan for the PACS implementation (£1.962m) is now expected in November, subject to SHA approval for the £1.0m loan element.

5.0 Capital Programme

5.1 The capital programme is £7.8m underspent at the end of September against a full year programme of £10.6m.

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

FINANCE REPORTS

September 06

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

CONSOLIDATED INCOME & EXPENDITURE SUMMARY

TRUST WIDE

FORM F1
September 06

Responsibility: Finance Director

	THIS MONTH			YEAR TO DATE			FULL YEAR			
							ORIGINAL	FULL YEAR	FORECAST	
	BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE	PLAN	BUDGET	ACTUAL	VARIANCE
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
INCOME										
Contract Income SaFF	(11,899)	(11,453)	(445)	(79,251)	(78,784)	(467)	(163,114)	(161,610)	(160,740)	(870)
Non-Contract Activity	(164)	(59)	(106)	(986)	(969)	(16)	(1,971)	(1,971)	(1,971)	0
Private Patients	(648)	(725)	77	(3,887)	(3,914)	26	(6,367)	(7,775)	(7,970)	196
Other Income	(5,511)	(5,276)	(235)	(33,422)	(32,987)	(436)	(64,650)	(66,298)	(65,779)	(519)
Donated Depreciation Income	(13)	(13)	0	(78)	(78)	0	(248)	(156)	(156)	0
TOTAL INCOME	**(18,234)**	**(17,526)**	**(709)**	**(117,624)**	**(116,732)**	**(892)**	**(236,350)**	**(237,810)**	**(236,616)**	**(1,193)**
EXPENDITURE			**0**							
Pay	11,443	10,160	1,283	62,775	56,587	6,188	130,925	126,098	101,396	24,702
Bank , Agency & Locum	(229)	333	(562)	139	6,140	(6,001)	980	203	24,557	(24,354)
Sub-total Pay	**11,215**	**10,493**	**722**	**62,914**	**62,727**	**187**	**131,905**	**126,301**	**125,953**	**347**
Non Pay	9,674	9,577	97	45,255	44,757	498	81,142	89,106	89,356	(250)
Sub-Total Non Pay	**9,674**	**9,577**	**97**	**45,255**	**44,757**	**498**	**81,142**	**89,106**	**89,356**	**(250)**
Reserves	(4,540)	(4,538)	(2)	0	4	(4)	0	4,236	3,092	1,144
Deficit Reversal/Surplus Brought Forward	0	0	0	0	0	0	0	0	0	0
Depreciation	709	701	8	4,255	4,206	50	11,259	8,511	7,411	1,100
Donated Depreciation	13	13	(0)	78	78	(0)	248	156	156	0
TOTAL EXPENDITURE	**17,071**	**16,246**	**825**	**112,502**	**111,771**	**731**	**224,554**	**228,309**	**225,968**	**2,341**
OPERATING SURPLUS	**1,164**	**1,280**	**116**	**5,122**	**4,961**	**(161)**	**11,796**	**9,501**	**10,648**	**1,148**
Profit/Loss on Disposal of Fixed Assets	0	0	0	0	0	0	0	0	0	0
SURPLUS BEFORE DIVIDENDS	**1,164**	**1,280**	**116**	**5,122**	**4,961**	**(161)**	**11,796**	**9,501**	**10,648**	**1,148**
Interest Receivable	(27)	(47)	21	(161)	(322)	161	(230)	(321)	(518)	197
Dividends	805	808	(3)	4,833	4,833	(0)	9,666	9,666	9,666	0
SURPLUS / (DEFICIT)	**385**	**519**	**134**	**450**	**450**	**0**	**2,360**	**156**	**1,500**	**1,345**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

FORM F2B(i)

SERVICE AGREEMENT VALUE SUMMARY

September 06

Responsibility: Finance Director

PCT	Original Annual Budget £000's	Agreed / latest Offer	Contract agreed Y/N	Variance on offer /agreed only
North West London Sector:				
KENSINGTON AND CHELSEA PCT	36,612,000	37,618,000	Y	1,006,000
WESTMINSTER PCT	15,119,000	14,702,251	Y	-416,749
HAMMERSMITH AND FULHAM PCT	20,034,800	20,217,039	Y	182,239
EALING PCT	3,063,000	2,702,506	Y	-360,494
HOUNSLOW PCT	3,445,000	3,719,603	Y	274,603
HILLINGDON PCT	518,000	486,000	Y	-32,000
BRENT PCT	1,489,000	1,468,501	Y	-20,499
HARROW PCT	507,000	495,364	Y	-11,636
South West London Sector				
WANDSWORTH PCT	14,142,803	13,521,273	Y	-621,530
RICHMOND AND TWICKENHAM PCT	2,455,000	2,269,000	Y	-186,000
KINGSTON PCT	441,000	429,490	Y	-11,510
CROYDON PCT	552,000	539,072	Y	-12,928
SUTTON AND MERTON PCT	850,000	800,000	Y	-50,000
North Central London Sector				
BARNET PCT	406,000	407,021	Y	1,021
HARINGEY PCT	271,000	269,043	Y	-1,957
ENFIELD PCT	195,000	184,915	Y	-10,085
ISLINGTON PCT	410,000	331,289	Y	-78,711
CAMDEN PCT	576,000	565,000	Y	-11,000
South East London Sector				
GREENWICH PCT	136,000	135,144	Y	-856
BEXLEY PCT	86,000	84,551	Y	-1,449
BROMLEY PCT	210,000	202,890	Y	-7,110
SOUTHWARK PCT	485,000	466,570	Y	-18,430
LEWISHAM PCT	292,000	285,450	Y	-6,550
LAMBETH PCT	1,362,000	1,331,604	Y	-30,396
North East London Sector:				
BARKING AND DAGENHAM PCT	160,000	121,528	Y	-38,472
HAVERING PCT	77,000	75,273	Y	-1,727
TOWER HAMLETS PCT	215,000	203,000	Y	-12,000
CITY AND HACKNEY PCT	225,000	228,078	Y	3,078
NEWHAM PCT	285,000	246,775	Y	-38,225
Other Major Non - London:				
REDBRIDGE PCT	127,000	128,896	Y	1,896
WALTHAM FOREST PCT	218,000	210,412	Y	-7,588
EAST ELMBRIDGE AND MID SURREY PCT	816,000	798,940	N	-17,060
EAST SURREY PCT	65,000	62,180	N	-2,820
BLACKWATER VALLEY AND HART PCT	465,000	465,000	Y	0
GUILDFORD AND WAVERLEY PCT	364,000	349,820	N	-14,180
NORTH SURREY PCT	625,000	616,790	N	-8,210
WOKING PCT	561,000	549,400	N	-11,600
HERTFORDSHIRE PCT's(8)	675,000	675,000	Y	0
WEST KENT PCTS (4)	249,000	246,431	Y	-2,569
EAST KENT PCTS (9)	667,000	499,001	Y	-167,999
BERKSHIRE PCT's (6)	508,000	508,000	Y	0
EAST SUSSEX PCT's (5)	341,000	331,827	Y	-9,173
WEST SUSSEX PCT's (5)	225,000	241,218	Y	16,218
HAMPSHIRE PCT's(6)	129,000	127,510	Y	-1,490
BEDFORDSHIRE PCT's(3)	220,000	190,159	Y	-29,841
NORTH ESSEX PCT's (8)	276,000	223,231	Y	-52,769
SOUTH ESSEX PCT's (5)	232,000	200,245	Y	-31,755
OXFORDSHIRE PCT's (5)	71,000		N	-71,000
DORSET PCT's (5)	76,000		N	-76,000
NORTHAMPTONSHIRE PCT' (3)	144,000	52,148	Y	-91,852
LINCOLNSHIRE PCT's (3)	62,000		N	-62,000
BUCKINGHAMSHIRE PCT's(4)	339,000	302,070	Y	-36,930
DEVON PCT's (4)	44,000	50,320	Y	6,320
BRISTOL PCT's(3)	6,000		N	-6,000
Specialised Services Consortia				
NICU CONSORTIUM	2,971,000	3,346,727	Y	375,727
HIV CONSORTIUM(KC)	43,649,800	43,348,000	Y	-301,800
Other				
Non Contracted activity (NCA)	1,957,000	1,957,000	Y	0
REVALUATION	230,000		N	-230,000
OTHER	181,000		N	-181,000
Market forces Factor	29,210,000	29,210,000	Y	0
Total Contract Income	**190,323,403**	**188,796,555**	**0**	**-1,526,848**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

SERVICE AGREEMENT VALUE SUMMARY

Responsibility: Finance Director

FORM F2B(ii)
September 06

PCT	Revised FY Budget at Month 6 £000's	Revised Target at Month 6 £000's	Actual at Month 6 £000's	Variance at Month 6 £000's
Contract and Over/Underperformance				
North West London Sector:				
Kensington & Chelsea	(37,866)	(18,933)	(18,788)	(145)
Westminster	(14,997)	(7,499)	(7,458)	(41)
Hammersmith & Fulham	(21,030)	(10,515)	(10,326)	(190)
Ealing	(2,703)	(1,351)	(1,341)	(10)
Hounslow	(3,720)	(1,860)	(1,933)	73
Hillingdon	(515)	(257)	(314)	57
Brent	(1,472)	(736)	(690)	(46)
Harrow	(495)	(248)	(305)	57
South West London Sector				
Wandsworth	(13,730)	(6,865)	(7,414)	549
Richmond & Twickenham	(2,408)	(1,204)	(1,027)	(177)
Kingston	(437)	(218)	(192)	(26)
Croydon	(539)	(270)	(317)	48
Sutton & Merton	(837)	(418)	(459)	41
North Central London Sector				
Barnet	(407)	(204)	(251)	47
Haringey	(269)	(135)	(149)	14
Enfield	(199)	(100)	(96)	(3)
Islington	(428)	(214)	(170)	(44)
Camden	(566)	(283)	(381)	98
South East London Sector				
Greenwich	(135)	(68)	(110)	42
Bexley	(85)	(42)	(48)	6
Bromley	(203)	(101)	(97)	(4)
Southwark	(472)	(236)	(256)	20
Lewisham	(285)	(143)	(153)	10
Lambeth	(1,357)	(679)	(628)	(50)
North East London Sector:				
Barking & Dagenham	(151)	(76)	(58)	(17)
Havering	(75)	(38)	(31)	(7)
Tower Hamlets	(214)	(107)	(92)	(15)
City & Hackney	(228)	(114)	(105)	(9)
Redbridge	(129)	(64)	(72)	8
Waltham Forest	(210)	(105)	(83)	(22)
Other Major Non - London:				
North Surrey	(616)	(308)	(297)	(11)
East Elmbridge and Mid Surrey	(816)	(408)	(523)	114
Woking	(555)	(277)	(205)	(73)
Blackwater Valley and Hart	(460)	(230)	(233)	3
Newham	(282)	(141)	(117)	(24)
Guildford and Waverley	(361)	(181)	(160)	(21)
Watford and Three Rivers	(194)	(97)	(95)	(2)
East Surrey	(63)	(31)	(50)	18
All Other PCTs	(4,592)	(2,296)	(2,018)	(278)
High Cost Drugs				
High Cost Drugs Exclusions Billed	0	0	(61)	61
Specialised Services Consortia				
NICU Consortium				
Hillingdon	(2,274)	(1,137)	(969)	(168)
Haringey	(153)	(76)	(76)	0
Bexley	(147)	(73)	(73)	(0)
Croydon	(705)	(352)	(352)	0
Tower Hamlets	(374)	(187)	(187)	0
Brent PCT	0	0	0	0
All Other PCTs	(211)	(106)	(106)	0
HIV Consortium & Overperformance				
Kensington & Chelsea	(38,993)	(17,942)	(16,827)	(1,115)
Out of London PCTs	(4,653)	(2,327)	(3,125)	799
GUM				0
Kensington & Chelsea	0	0	0	0
Hammersmith & Fulham	0	0	0	0
Other				
London Patient Choice (Receiving)	0	0	0	0
Non Contract Activity	0	0	0	0
Non Contract Activity Overseas/Cross Border	0	0	0	0
Revenue Incentive Payment	0	0	0	0
Prior year	0	0	37	(37)
Other income from PCTs	0	0	0	0
Prior Year Deficit Reversal and Surplus Carry Forward	0	0	0	0
Balance on 9D Codes	0	0	0	0
Balance on 9A Codes	0	0	0	0
Total Contract Income	**(161,610)**	**(79,251)**	**(78,783)**	**(467)**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

SERVICE AGREEMENT ACTIVITY SUMMARY - BY PCT

Responsibility: Finance Director

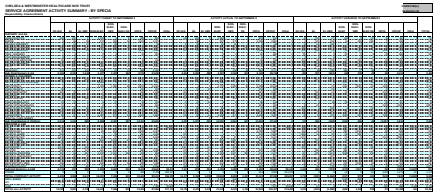
FORM F2B(iii)

September 06

	ACTIVITY TARGET TO SEPTEMBER 06									ACTIVITY ACTUAL TO SEPTEMBER 06									ACTIVITY VARIANCE TO SEPTEMBER 06									
	DC+DA	EL	EL XBD	NON-ELEC	NON-ELEC- XBD	NON-ELEC-SS	OPFA	OPFUP	Other	DC+DA	EL	EL XBD	NON-ELEC	NON-ELEC- XBD	NON-ELEC-SS	OPFA	OPFUP	Other	DC+DA	EL	EL XBD	NON-ELEC	NON-ELEC- XBD	NON-ELEC-SS	OPFA	OPFUP	Other	TOTAL
North West London Sector:																											
KENSINGTON & CHELSEA	2,587	730	538	3,723	2,055	175	9,908	26,108	60,137	3,045	687	197	4,112	2,176	297	9,386	25,410	57,627	458	-43	-341	389	-121	-122	-522	-698	-2,511	-3,026
WESTMINSTER	1,596	575	472	1,477	1,019	65	4,695	12,266	22,481	1,907	516	174	1,580	878	110	4,520	13,549	23,765	311	-59	-298	103	-141	-45	-175	-1,283	-1,284	-2,354
HAMMERSMITH & FULHAM	1,667	593	416	2,895	1,165	114	6,723	14,420	32,202	1,930	469	84	3,374	1,178	197	6,238	15,037	32,996	263	-124	-332	479	-13	-83	-485	-617	-794	-1,309
EALING	338	144	46	369	97	12	916	2,004	3,720	438	163	42	350	188	13	946	2,744	4,039	100	-19	-4	19	-91	-1	-30	-740	-319	-1,278
HOUNSLOW	462	172	96	364	265	14	939	2,084	4,737	589	152	71	440	501	18	932	2,752	4,752	127	-20	-25	76	-236	-4	-7	-668	-14	-1,074
HILLINGDON	40	36	7	51	5	5	103	257	407	46	36	8	53	50	2	98	373	406	6	-0	-1	2	-45	-3	-5	-116	-1	-161
BRENT	151	77	26	170	163	13	326	810	1,229	228	94	13	146	70	7	381	1,404	1,229	77	-17	-13	24	-93	-6	-55	-584	-0	-608
HARROW	34	18	3	84	34	1	75	168	332	27	18	8	89	18	3	78	230	332	-7	-0	-5	5	-16	-2	-3	-62	-1	-54
SOUTH WEST LONDON SECTOR																												
WANDSWORTH	997	366	241	2,671	1,532	97	4,283	10,734	13,621	1,315	362	71	3,176	1,728	201	4,142	11,902	13,646	318	-4	-170	505	-196	-104	-141	-1,168	-25	-1,999
RICHMOND & TWICKENHAM	219	80	29	422	92	21	602	2,657	2,535	314	90	1	596	187	14	831	2,465	2,536	95	-10	-28	174	-95	-7	-229	-192	-1	-376
KINGSTON	40	27	24	47	11	2	105	291	460	27	22	12	50	29	4	119	412	460	13	-5	-12	3	-18	-2	-14	-121	-0	-128
CROYDON	35	33	14	63	7	3	104	321	553	61	19	0	85	61	5	102	424	555	26	-14	-14	22	-54	-2	-2	-103	-2	-178
SUTTON & MERTON	71	40	2	106	35	7	279	687	379	134	22	5	172	49	3	262	864	392	63	-18	-3	66	-14	-4	-17	-177	-13	-298
NORTH CENTRAL LONDON SECTOR																												
BARNET	33	17	45	53	4	1	103	284	350	37	17	0	87	23	4	65	319	343	4	-0	-45	34	-19	-3	-38	-35	-7	-4
HARINGEY	38	7	3	50	3	1	75	189	288	70	10	0	43	19	5	79	268	284	32	-3	-3	7	-16	-4	-4	-79	-4	-122
ENFIELD	9	12	2	27	4	1	42	129	201	24	9	0	31	6	3	52	172	202	15	-3	-2	4	-2	-2	-10	-43	-2	-72
ISLINGTON	21	17	1	33	8	3	65	211	473	21	9	0	27	9	2	84	343	472	0	-8	-1	6	-1	-1	-19	-132	-1	-135
CAMDEN	45	32	39	53	32	4	132	360	607	37	14	0	94	30	10	115	521	607	-8	-18	-39	41	-2	-6	-17	-161	-1	-124
SOUTH EAST LONDON SECTOR																												
GREENWICH	7	8	1	15	11	1	54	154	278	9	6	4	41	42	1	36	201	276	2	-2	-3	26	-31	-0	-18	-47	-2	-88
BEXLEY	2	3	7	7	17	-	25	71	95	4	7	15	11	2	1	20	99	94	2	-4	-8	4	-15	-1	-5	-28	-1	-26
BROMLEY	27	14	15	24	9	1	43	133	3	15	16	3	30	18	3	48	181	3	12	-2	-12	6	-9	-2	-5	-48	-1	-49
SOUTHWARK	35	24	21	68	20	2	148	397	814	29	15	0	78	5	8	165	508	817	-6	-9	-21	10	-15	-6	-17	-111	-3	-96
LEWISHAM	18	14	16	36	29	3	92	279	449	11	11	0	24	10	1	84	303	449	-7	-3	-16	12	-19	-2	-8	-24	-0	-42
LAMBETH	216	45	35	184	199	19	347	895	2,043	109	63	12	153	101	18	434	1,221	2,048	-107	-18	-23	31	-98	-1	-87	-326	-5	-175
NORTH EAST LONDON SECTOR:																												
BARKING & DAGENHAM	4	7	2	16	9	0	31	93	108	5	8	0	15	15	-	18	81	108	1	1	-2	1	-6	-0	-13	-12	-0	-20
HAVERING	5	7	8	20	1	1	24	62	99	5	4	1	6	22	1	14	78	97	-0	-3	-7	14	-21	-0	-10	-16	-2	-0
TOWER HAMLETS	51	8	-	44	47	1	42	160	311	23	11	0	39	13	2	47	203	309	-28	-3	-	5	-34	-1	-5	-43	-2	-17
CITY & HACKNEY	13	10	4	42	9	1	67	147	309	6	12	0	34	69	1	68	226	314	-7	-2	-4	8	-60	-0	-1	-79	-5	-128
REDBRIDGE	13	6	1	42	2	1	34	106	165	25	9	0	15	19	2	35	141	163	-12	-3	-1	27	-17	-1	-1	-35	-2	-38
WALTHAM FOREST	14	10	28	48	15	1	41	165	207	20	7	0	21	27	1	38	167	204	-6	-3	-28	27	-12	-0	-3	-2	-3	-44
OTHER MAJOR NON - LONDON:																												
NORTH SURREY	84	39	41	55	13	8	61	215	402	83	44	32	51	16	1	71	384	404	-1	-5	-9	4	-3	-7	-10	-169	-2	-167
EAST ELM & MID SURREY	163	66	213	66	17	3	130	399	518	69	52	14	82	18	1	103	455	518	-94	-14	-199	16	-1	-2	-27	-56	-	-264
WOKING	69	34	47	64	43	1	100	237	328	70	21	0	55	4	-	90	266	328	1	-13	-47	9	-39	-1	-10	-29	-1	-88
BLACKWATER VALLEY	51	23	8	46	5	3	106	265	318	51	19	0	68	17	2	101	255	317	0	-4	-8	22	-12	-1	-5	-10	-1	-4
NEWHAM PCT	17	12	12	34	14	1	62	158	275	12	10	10	88	32	-	45	208	281	5	-2	-2	54	-18	-1	-17	-50	-6	-100
GUILDFORD & WAVERLEY	25	12	2	45	5	3	49	138	243	25	12	0	44	9	-	51	175	243	0	-0	-2	1	-4	-3	-2	-37	-0	-38
WATFORD & THREE RIVERS	17	13	7	23	-	1	36	89	152	9	17	0	14	5	3	44	130	151	-8	-4	-7	9	-5	-2	-8	-41	-0	-36
EAST SURREY	7	5	3	5	2	0	18	68	61	15	8	0	5	4	1	14	73	62	-8	-3	-3	0	-2	-1	-4	-5	-1	-14
ALL OTHER 'S	261	217	169	607	241	12	656	2,032	4,932	545	211	290	663	414	16	654	2,443	3,186	284	-6	-121	56	-173	-4	-2	-411	-1,747	-706
NICU CONSORTIUM	-	-	-	2,048	-	-	-	-	-	-	-	-	2,247	-	-	-	-	-	-	-	-	200	-	-	-	-	-	**200**
TOTAL CONTRACT ACTIVITY	**9,481**	**3,556**	**2,647**	**16,197**	**7,236**	**603**	**31,643**	**80,243**	**156,823**	**11,390**	**3,272**	**1,067**	**18,289**	**8,062**	**961**	**30,610**	**86,987**	**155,017**	**1,909**	**-284**	**-1,580**	**2,092**	**-826**	**-358**	**-1,033**	**-6,744**	**-1,807**	**7,225**
HIV/GUM & Well babies	1,219	51	139	251	348	-	10	7,323	20,900	368	201	139	2,850	1,071	201	1,315	23,988	23,248	-852	150	-	2,599	723	201	1,305	16,665	2,348	23,140
TOTAL ALL ACTIVITY	**10,700**	**3,607**	**2,786**	**16,448**	**7,584**	**603**	**31,653**	**87,566**	**177,723**	**11,758**	**3,473**	**1,206**	**21,139**	**9,133**	**1,162**	**31,925**	**110,975**	**178,265**	**1,057**	**-134**	**-1,580**	**4,691**	**-1,549**	**559**	**272**	**23,409**	**541**	**30,365**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

SERVICE AGREEMENT ACTIVITY SUMMARY - BY SPECIA



CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

SUMMARY SALARIES AND WAGES

Responsibility:

TRUST WIDE

FORM F2D
September 06

	Full Year Budget £000s	THIS MONTH				YEAR TO DATE			
		Budget £000s	Actuals £000s	Variance £000s	Variance % £000s	Budget £000s	Actual £000s	Variance £000s	Variance % £000s
MEDICAL									
Senior Medical	22,085	1,764	1,755	10	0.55%	11,091	11,120	(29)	-0.26%
Junior Medical	18,714	1,593	1,491	102	6.41%	9,350	8,674	676	7.23%
Other Medical & Dental	13	1	0	1	100.00%	7	0	7	99.77%
Medical Locum	(0)	0	107	(107)		0	999	(999)	
Medical sub total	**40,812**	**3,358**	**3,353**	**6**	**0.17%**	**20,448**	**20,793**	**(346)**	**-1.69%**
AGENDA FOR CHANGE									
Agenda for Change Bands 1-4	720	260	(1)	260	100.19%	627	(1)	627	100.08%
Agenda for Change Bands 5-9	0	0	(18)	18	55260.61%	0	(18)	18	9233.84%
Agenda for Change sub total	**720**	**260**	**(19)**	**278**	**107.21%**	**627**	**(19)**	**645**	**102.96%**
NURSING & MIDWIFERY									
Trained Nursing	44,213	3,057	2,300	758	24.78%	22,201	18,067	4,134	18.62%
Untrained Nursing	4,338	260	170	90	34.65%	2,186	1,827	358	16.40%
Health Care Assistants	158	14	55	(41)	-291.60%	86	92	(6)	-7.09%
Bank Nursing & Midwifery	64	7	82	(75)		42	2,800	(2,758)	
Agency Nursing & Midwifery	22	2	53	(52)		11	740	(729)	
Nursing & Midwifery sub total	**48,795**	**3,341**	**2,660**	**680**	**20.36%**	**24,526**	**23,527**	**999**	**4.08%**
AHPs									
Dieticians	121	9	7	1	16.06%	68	51	17	24.56%
Radiographers	491	41	9	32	77.31%	246	68	178	72.36%
Therapists	532	172	97	74	43.35%	322	236	86	26.62%
AHPs AFC	5,356	452	509	(57)	-12.71%	2,664	2,834	(169)	-6.35%
Agency/Locums (AHPs)	0	(16)	30	(45)		0	189	(189)	
PTA - sub totals	**6,501**	**658**	**653**	**5**	**0.71%**	**3,300**	**3,377**	**(78)**	**-2.36%**
OTHER									
Pharmacists	2,671	363	286	77	21.14%	1,335	1,257	77	5.81%
Scientific & Professional AFC	433	7	67	(60)	-867.93%	208	387	(179)	-85.90%
Healthcare Scientists AFC	3,651	481	365	116	24.12%	1,799	1,479	320	17.80%
Chaplains	0	0	0	0	0.00%	0	0	0	0.00%
All Other	3,111	(233)	268	(501)	215.09%	518	1,770	(1,252)	-241.76%
Other sub	**9,866**	**617**	**986**	**(369)**	**-59.76%**	**3,860**	**4,892**	**(1,033)**	**-26.76%**
ADMIN									
Admin & Clerical	16,310	1,192	1,218	(26)	-2.19%	8,148	6,859	1,288	15.81%
Bank Admin & Clerical	77	(225)	(20)	(205)		66	1,030	(964)	
Agency Admin & Clerical	40	3	76	(72)		20	378	(358)	
Senior Managers & Trust Board	4,759	59	(232)	291	489.14%	2,307	1,889	418	18.13%
Agency Other	0	0	0	0		0	0	0	
Admin - sub total	**21,186**	**1,030**	**1,043**	**(13)**	**-1.22%**	**10,541**	**10,156**	**385**	**3.65%**
Payroll	**127,879**	**9,263**	**8,676**	**587**	**6.34%**	**63,301**	**62,727**	**574**	**0.91%**
Unidentified Savings	(1,579)	134	0	134		(387)	0	(387)	
PAY TOTAL	**126,301**	**9,398**	**8,676**	**722**	**7.68%**	**62,914**	**62,727**	**187**	**0.30%**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

SUMMARY NON PAY EXPENDITURE

TRUST WIDE

FORM F2E
September 06

Responsibility:

NON PAY EXPENDITURE	Full Year Budget £000s	THIS MONTH				YEAR TO DATE			
		This Months Budget £000s	This Months Actuals £000s	This Months Variance £000s	This Months Variance % £000s	Year to Date Budget £000s	Year to Date Actual £000s	Year to Date Variance £000s	Year to Date Variance % £000s
DRUGS (incl HIV/GUM) & MEDICAL GASES	33,069	2,555	2,157	398	16%	16,702	16,153	549	3%
MEDICAL & SURGICAL EQUIPMENT & DRESSINGS	6,563	554	683	-129	-23%	3,338	3,756	-418	-13%
X-RAY FILM, EQUIP & MATERIALS	1,486	134	157	-23	-17%	749	757	-7	-1%
LABORATORY EQUIP & MATERIALS	260	22	25	-4	-16%	130	173	-43	-32.92%
PATIENT APPLIANCES / PROTHESES	1,553	129	225	-95	-74%	777	1,111	-335	-43.10%
BLOOD PRODUCTS	1,117	73	111	-38	-52%	558	649	-91	-16.25%
PATHOLOGY SERVICES	7,472	873	789	84	10%	3,896	4,093	-197	-5.06%
OTHER TESTS	547	57	23	34	60%	279	186	94	33.46%
SERVICE LEVEL AGREEMENT	3,843	453	615	-162	-36%	1,921	2,037	-116	-6.02%
CONTRACT SERVICES			0			0	0		
Contract Catering	2,067	198	197	0	0%	1,033	1,047	-13	-1.29%
Domestics	2,628	531	512	20	4%	1,467	1,497	-30	-2.02%
Portering	984	98	99	-1	-1%	502	495	7	1.41%
Carparking	14	1	1	-0	-14%	7	16	-9	-135.62%
Laundry Contract	788	73	98	-25	-34%	394	502	-108	-27.42%
Change control Levy, CCNs	75	6	-61	67	1075%	38	-82	119	317.99%
Carillion Management Charge	951	96	126	-30	-32%	474	538	-64	-13.54%
Total Bed Management Contract / Lease	169	14	28	-14	-103%	84	79	5	6.51%
IT Services	0	0	0	0	0%	0	0	0	0.00%
Other External Contracts	1,298	171	182	-12	-7%	676	739	-62	-9.19%
PROVISIONS & OTHER CATERING	5	0	123	-123	-37259%	3	186	-183	-5940.64%
LAUNDRY, LINEN, UNIFORMS & CLOTHING	86	7	10	-3	-35%	43	62	-18	-42.56%
CLEANING EQUIPMENT	0	0	0	0	0%	0	0	0	0.00%
LEGAL FEES	3,602	345	371	-26	-8%	1,825	1,823	2	0.10%
PRINTING, STATIONERY & POSTAGE	866	73	213	-140	-191%	434	578	-144	-33.26%
TELEPHONES	645	64	80	-16	-25%	322	359	-37	-11.48%
TRAVEL, SUBSISTENCE & REMOVALS	187	16	25	-9	-60%	93	134	-42	-44.87%
TRANSPORT	1,100	108	111	-2	-2%	550	669	-119	-21.70%
ADVERTISING & PUBLICITY	366	30	18	13	42%	183	119	64	34.73%
TRAINING	663	52	29	23	45%	351	215	136	38.66%
ENERGY & WATER	3,477	286	221	65	23%	1,624	1,265	359	22.12%
FURNITURE, FITTINGS & OFFICE EQIPMENT	247	21	17	4	17%	122	94	27	22.50%
IT EQUIPMENT & SUPPLIES	1,674	108	67	41	38%	847	819	28	3.34%
RENT & RATES	2,195	251	251	-0	0%	1,088	1,104	-17	-1.53%
ESTATES MAINTENANCE	2,162	219	305	-86	-39%	1,081	1,266	-185	-17.13%
CONSULTANCY	1,071	187	340	-152	-81%	605	881	-276	-45.59%
WARD BUDGETS	0	0	0	0	0%	0	0	0	0.00%
BAD DEBT PROVISION	1,100	1,100	917	183	17%	1,100	587	513	46.68%
OTHER EXPENDITURE	4,554	-1,725	-1,884	159	-9%	1,853	848	1,005	54.24%
FACILITIES /THEATRE RECHARGES	22	2	0	2	100%	11	-0	11	100.02%
CIP NON PAY SAVINGS	200	95	0	95	100%	93	0	93	100.00%
Non Pay	**89,106**	**7,277**	**7,180**	**97**	**1%**	**45,255**	**44,757**	**499**	**1.10%**
Depreciation	8,411	701	701	0	0%	4,206	4,206	0	0.00%
CIP Depreciation Savings	99	8	0	8	100%	50	0	50	100.00%
Donated Depreciation	156	13	13	-0	0%	78	78	-0	-0.01%
DIVIDENDS PAYABLE	9,666	805	808	-3	0%	4,833	4,833	-0	0.00%
Deficit Reversal/Surplus Brought Forward	0	0	0	0	0%	0	0	0	0.00%
Reserves	4,236	0	2	-2	-27300%	0	4	-4	-9040.48%
TOTAL NON PAY	**111,675**	**8,804**	**8,704**	**100**	**1%**	**54,421**	**53,877**	**545**	**1.00%**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

SERVICE LEVEL AGREEMENTS EXPENDITURE

Responsibility: Edward Donald

FORM F2F
September 06

Account	Service Level Agreement	Budget Holder	Full Year Budget £000	THIS MONTH				YEAR TO DATE			
				This Months Budget £000	This Months Actuals £000	This Months Variance £000	This Months Variance %	Year to Date Budget £000	Year to Date Actual £000	Year to Date Variance £000	Year to Date Variance %
3A040	BLOOD PRODUCTS		36	18	16	2	11.1%	18	6	12	66.7%
3A250	NATIONAL BLOOD SERVICE CONTRAC		1,080	55	95	(40)	-72.7%	540	647	(113)	-20.9%
3C010	PRINTING & STATIONARY (INC. CO		0	0	0	0	0.0%	0	0	0	0.0%
3C060	TELECOMMUNICATIONS SLA		0	0	0	0	0.0%	0	0	0	0.0%
3D160	COMPUTER HARDWARE PURCHASES		0	0	0	0	0.0%	0	0	0	0.0%
3D250	RENT & ACCOMMODATION SERVICEWS		459	75	68	7	9.3%	229	236	(7)	-3.1%
3H030	MISCELLANEOUS		0	0	0	0	0.0%	0	0	0	0.0%
3H120	HOSPITALITY		0	0	0	0	0.0%	0	0	0	0.0%
3H200	SOCIAL SERVICES		142	12	32	(20)	-166.7%	72	96	(24)	-33.3%
3H210	MEDICAL ILLUSTRATION		345	34	35	(3)	-8.8%	173	183	(10)	-5.8%
3H220	A/V SERVICES		0	0	0	0	0.0%	0	0	0	0.0%
3J010	NATIONAL AMBULANCE		0	0	0	0	0.0%	0	0	0	0.0%
3J030	PATHOLOGY SLA (HHT)		6,636	804	716	88	10.9%	3,440	3,612	(172)	-5.0%
3J040	CARDIOLOGY SLA (RBH)		0	0	0	0	0.0%	0	0	0	0.0%
3J050	INFORMATION SYSTEMS SLA		0	0	0	0	0.0%	0	0	0	0.0%
3J060	CLINICAL ENGINEERING SLA		519	40	114	(74)	-185.0%	259	270	(11)	-4.2%
3J070	EEG SLA		0	0	0	0	0.0%	0	0	0	0.0%
3J080	MEDICAL PHYSICS SLA		78	26	13	13	50.0%	39	52	(13)	-33.3%
3J090	PSYCHOLOGY SLA		0	0	0	0	0.0%	0	0	0	0.0%
3J110	CLINICAL HAEMATOLOGY SLA		0	0	10	(10)	0.0%	0	10	(10)	0.0%
3J120	OBSTETRICS COVER		0	0	0	0	0.0%	0	0	0	0.0%
3J130	RADIATION PHYSICS SLA		90	35	48	(13)	-37.1%	45	59	(14)	-31.1%
3J140	CVP UNIT SLA		0	0	0	0	0.0%	0	0	0	0.0%
3J150	GUM CLINIC OVERHEADS		0	0	0	0	0.0%	0	0	0	0.0%
3J160	PAEDIATRICS/CDC OVERGEADS		0	0	0	0	0.0%	0	0	0	0.0%
3J180	SPEECH THERAPY		211	29	53	(24)	-82.8%	105	123	(18)	-17.1%
3J190	VICTORIA SHC SLA		118	59	57	2	3.4%	59	57	2	3.4%
3J200	EXTERNAL TESTS		0	0	11	(11)	0.0%	0	0	0	0.0%
3J210	PHARMACY SLA (HHT)		0	0	0	0	0.0%	0	0	0	0.0%
3J500	SERVICES NHS BODIES SUBCONTRAC		0	0	0	0	0.0%	0	0	0	0.0%
3J510	PLASTICS OUTREACH SLA		0	0	4	(4)	0.0%	0	9	(9)	0.0%
3J520	BURNS OUTREACH SLA		0	0	0	0	0.0%	0	0	0	0.0%
3J530	PAEDIATRIC ENT SLA		0	0	0	0	0.0%	0	0	0	0.0%
9B011	PROVIDER TO PROVIDER INCOME- BROMPTON		(230)	(29)	0	(29)	100.0%	(115)	(63)	(52)	45.2%
9B012	PROVIDER TO PROVIDER INCOME- MARSDEN		(147)	(35)	(172)	137	-391.4%	(74)	(222)	148	-200.0%
VF010	SLAs SAVINGS TARGET 2005/06		0	0	0	0		0	0	0	
Vf042	SLAs SAVINGS TARGET 2006/07		0	77	0	77		0	0	0	
	TOTAL ALL SLAs		**9,337**	**1,200**	**1,100**	**98**	**8.2%**	**4,790**	**5,075**	**(291)**	**-6.1%**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

TRUST WIDE SUMMARY BY DIRECTORATE

Responsibility: Finance Director

FORM F3A
September 06

Directorate/ Service Area	Accountability	Annual Budget					In Month Variance					YTD Variance					Full Year Forecast at September 06				
		Income	Pay	Savings	Non pay	Total	Income	Pay	Savings	Non Pay	Total	Income	Pay	Savings	Non Pay	Total	Income	Pay	Non pay	Total	Change in Forecast
Central Income		£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SaFF income	Lorraine Bewes	(162,252)	0	0	0	(162,252)	(513)	0	0	69	(444)	(271)	0	0	(65)	(335)	(932)	0	0	(932)	(114)
Central Non SaFF income	Lorraine Bewes	(55,630)	0	0	0	(55,630)	(326)	0	0	0	(326)	(822)	0	0	0	(822)	(1,120)	0	0	(1,120)	0
Total Central Income		(217,883)	0	0	0	(217,883)	(838)	0	0	69	(770)	(1,093)	0	0	(65)	(1,158)	(2,052)	0	0	(2,052)	(114)
Frontline Directorate																					
Imaging & Anaesthetics	Kate Hall	(494)	20,881	0	5,332	25,718	10	32	(0)	(95)	(53)	24	(22)	(0)	(152)	(150)	99	15	(192)	(78)	1
HIV/GUM	Debbie Richards	(1,262)	11,059	(210)	27,138	36,724	(122)	(44)	24	348	206	17	(54)	(132)	346	177	200	(372)	355	183	183
Medicine & A&E	Nicola Hunt	(711)	22,971	(344)	7,045	28,961	36	(1)	166	6	207	90	(298)	(154)	52	(310)	179	(860)	213	(468)	3
Surgery	Kate Hall	(339)	14,407	0	4,110	18,178	(0)	40	(0)	(80)	(40)	35	20	(0)	(314)	(258)	34	213	(405)	(158)	0
Womens & Children's	Sherryn Elsworth	(3,976)	31,056	(64)	4,426	31,442	(3)	111	(5)	(129)	(27)	(210)	(217)	(32)	37	(422)	51	(413)	(35)	(397)	(199)
Subtotal Frontline Directorates		(6,782)	100,374	(619)	48,051	141,024	(80)	138	184	50	292	(44)	(572)	(318)	(30)	(964)	563	(1,417)	(64)	(918)	(12)
Pharmacy	Karen Robertson	(763)	4,247	0	351	3,835	(7)	15	0	5	13	(23)	99	0	12	88	0	115	30	145	0
Physiotherapy & Occ Therapy	Douline Schoeman	(200)	4,022	0	139	3,961	7	3	(0)	(9)	0	(2)	(74)	(0)	(2)	(78)	(6)	7	(5)	(4)	(11)
Dietetics	Helen Stracey	(25)	604	0	25	604	(1)	5	0	1	4	(5)	6	0	1	2	(10)	12	3	5	12
Regional Pharmacy	Susan Sanders	(59)	65	0	21	26	(5)	5	0	1	1	(30)	26	0	10	6	0	0	0	0	0
Subtotal Clinical Support		(1,047)	8,937	0	537	8,427	(6)	28	0	(2)	19	(59)	57	0	21	19	(16)	134	28	146	1
Chief Executive	Heather Lawrence	(40)	1,052	0	294	1,306	(4)	22	0	(1)	17	24	59	0	(4)	79	24	60	1	85	12
Governance & Corporate Affairs	Cathy Mooney	(3)	744	0	3,504	4,244	(0)	23	0	(4)	19	(1)	101	0	(11)	89	(1)	117	(12)	104	15
Nursing	Andrew MacCallum	(920)	2,221	0	215	1,515	(17)	26	0	(6)	2	(7)	112	0	(14)	91	(16)	94	(21)	57	0
Human Resources	Maxine Foster	(111)	1,654	0	173	1,716	(7)	13	0	7	13	(11)	32	0	9	30	(11)	32	9	30	13
Finance	Lorraine Bewes	(1,034)	3,495	0	962	3,424	18	0	0	(24)	(5)	166	(81)	0	(68)	17	197	(107)	(76)	14	14
IC&T & EPR	Alex Geddes	(78)	1,756	0	1,572	3,251	(0)	35	0	(3)	32	(1)	171	0	(70)	100	(1)	189	(62)	126	90
Occupational Health	Stella Sawyer	(173)	352	0	55	233	(3)	4	0	2	2	(20)	5	(0)	(4)	(19)	(32)	8	2	(22)	3
Subtotal Management Exec		(2,359)	11,273	0	6,775	15,689	(13)	124	0	(30)	80	149	400	0	(162)	386	160	393	(159)	394	147
Facilities Management	Helen Elkington	(2,708)	241	0	17,541	15,074	11	5	(0)	(13)	3	22	5	(0)	(40)	(14)	115	12	(163)	(36)	(5)
Operation Management	Edward Donald	0	760	0	7	767	0	(8)	0	(0)	(8)	0	6	0	1	8	0	2	1	3	(6)
Research & Development	Mervyn Maze	0	0	0	0	0	0	(5)	0	0	(5)	10	(15)	0	(0)	(5)	0	0	0	0	0
Private Patients	Edward Donald	(3,698)	954	0	481	(2,263)	86	(16)	0	(34)	37	(65)	(73)	0	(86)	(223)	(41)	(122)	(171)	(334)	3
Overseas	Edward Donald	(718)	36	0	0	(682)	(10)	3	0	(5)	(12)	61	4	0	(42)	23	0	0	0	0	0
ACU	Sherryn Elsworth	(1,256)	735	0	440	(81)	4	(16)	0	(16)	(28)	181	(29)	0	(61)	90	272	(46)	(109)	117	(1)
Post Graduate Centre	Kevin Shotlift	0	92	0	132	224	0	(0)	0	(8)	(8)	(3)	0	0	(11)	(13)	0	0	0	0	0
Projects	Edward Donald	(162)	1,122	0	136	1,096	3	(0)	0	6	9	16	3	0	12	31	23	(27)	22	18	(5)
Simulation Centre	Andrew MacCallum	(293)	259	0	37	4	15	5	0	(43)	(23)	(16)	42	0	(36)	(10)	0	0	0	0	0
Service Level Agreements	Edward Donald	(377)	0	0	9,714	9,337	100	(2)	78	(79)	97	89	(1)	(3)	(376)	(291)	0	0	(931)	(931)	0
Subtotal Other Directorates		(9,211)	4,199	0	28,488	23,477	210	(34)	77	(191)	62	296	(59)	(3)	(639)	(405)	369	(181)	(1,351)	(1,163)	(14)
Total All Directorates		(19,399)	124,783	(619)	83,850	188,616	110	255	262	(174)	453	341	(174)	(321)	(809)	(963)	1,076	(1,071)	(1,546)	(1,541)	122
Central Budgets																					0
Capital Charges	Lorraine Bewes	(156)	0	0	18,233	18,077	0	0	(0)	(3)	(3)	0	0	(0)	(0)	(0)	0	0	1,100	1,100	1,100
Central Budgets	Lorraine Bewes	(693)	985	(661)	2,765	2,395	41	331	(23)	105	454	22	747	76	1,275	2,121	(20)	1,418	1,296	2,694	237
Reserves	Lorraine Bewes	0	2,112	0	6,527	8,639	0	0	0	0	0	0	0	0	0	0	0	0	1,144	1,144	0
Total Central Budgets		(849)	3,097	(661)	27,525	29,111	41	331	(23)	103	451	22	747	76	1,275	2,121	(20)	1,418	3,540	4,938	1,337
Net Deficit(-)/Surplus(+)		(238,131)	127,879	(1,280)	111,376	(156)	(688)	586	239	(3)	135	(731)	574	(244)	402	0	(996)	347	1,994	1,345	1,345

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

ACU Summary

FORM F3B
September 06

	IN MONTH PLAN ACTIVITY	IN MONTH ACTUAL ACTIVITY	IN MONTH VARIANCE ACTIVITY	YTD PLAN ACTIVITY	YTD ACTUAL ACTIVITY	YTD VARIANCE ACTIVITY	ANNUAL PLAN ACTIVITY	YE FORECAST ACTIVITY	VARIANCE TO PLAN ACTIVITY
Activity Cycles per year									
IVF	15	12	(3)	90	103	13	180	197	17
ICSI	10	13	3	60	71	11	120	136	16
Sub total self fund cycles	**25**	**25**	**0**	**150**	**174**	**24**	**300**	**334**	**34**
IUI (procedure)	30	31	1	180	220	40	360	422	62

	IN MONTH PLAN £000	IN MONTH ACTUAL £000	IN MONTH VARIANCE £000	YTD PLAN £000	YTD ACTUAL £000	YTD VARIANCE £000	ANNUAL PLAN £000	YE FORECAST £000	VARIANCE TO PLAN £000
Income									
IVF	(35)	(25)	(10)	(209)	(241)	32	(418)	(499)	81
ICSI	(28)	(31)	3	(168)	(208)	40	(336)	(406)	70
Sub total self fund cycles	**(63)**	**(56)**	**(7)**	**(377)**	**(450)**	**73**	**(754)**	**(905)**	**151**
IUI	(18)	(18)	0	(110)	(153)	44	(219)	(271)	51
Consultations	(2)	(2)	(0)	(15)	(22)	8	(29)	(37)	8
Drugs income	(18)	(30)	12	(106)	(141)	35	(212)	(260)	48
Other	(3)	(2)	(1)	(21)	(42)	22	(42)	(56)	14
Income sub total	**(105)**	**(108)**	**4**	**(628)**	**(809)**	**181**	**(1,256)**	**(1,528)**	**272**
Pay	61	77	(16)	367	396	(29)	735	781	(46)
Non pay	37	53	(16)	220	281	(61)	440	549	(109)
Surplus/ Deficit	**(7)**	**21**	**(28)**	**(41)**	**(131)**	**90**	**(81)**	**(198)**	**118**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

SUMMARY OF RESERVES MOVEMENTS

Responsibility: Finance Director

FORM 4A

September 06

Reserve	Code	Revised Opening Balance 01/04/06	Distributed 2006/07							Closing Ledger balance 2006/07	Committed 2006/07	Uncomm-itted 2006/07	Uncomm-itted 2007/08
			Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total				
		£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Specific Expenditure Reserves	3X010	**16,775**	(3,266)	(1,064)	(2,101)	(559)	(497)	(4,152)	**(11,639)**	**5,136**	**3,882**	**1,254**	**0**
Pay Inflation	3X060	**3,228**		(739)	(1,244)	(333)	(91)	(44)	**(2,451)**	**777**	**777**	**0**	**0**
Non Pay	3X070	**7,124**	(1,456)	(2,768)	(320)	(118)	(32)	(444)	**(5,138)**	**1,986**	**1,925**	**61**	**0**
Contingency	3X080	**41**	(15)	(19)	18	(164)	(4)	(102)	**(286)**	**(245)**	**(40)**	**(205)**	**0**
Deficit Payback	3X195	**2,360**		(2,360)		0			**(2,360)**	**0**		**0**	**0**
Agenda for Change Reserve	3X250	**2,903**	(435)	(642)		(410)	(231)	(127)	**(1,845)**	**1,058**	**1,018**	**40**	**0**
EWTD Reserve	3X260	**543**		(126)	(80)	(107)		50	**(263)**	**280**	**280**	**0**	**0**
Consultant Contract Reserve	3X290	**198**				(30)	(8)		**(38)**	**160**	**160**	**(0)**	**0**
Additional Savings	3X490	**0**			193	(193)			**0**	**0**	**0**	**0**	**0**
Drugs Reserve	3X510	**0**		158	(37)	0			**121**	**121**	**128**	**(7)**	**0**
Ringfenced Funding	3X680	**0**	(555)	(20)	677	(22)	(7)	(708)	**(635)**	**(635)**	**(635)**	**0**	**0**
		0											
		33,173	**(5,728)**	**(7,580)**	**(2,894)**	**(1,936)**	**(870)**	**(5,527)**	**(24,534)**	**8,639**	**7,495**	**1,144**	**0**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

TRUST WIDE SAVINGS ACHIEVED BY DIRECTORATE

Responsibility: Finance Director

FORM F5A
September 06

Directorate/ Service Area	Accountability	2005/06 B/F target	New Target 2006/07	Total Target 2006/07	Savings Planned/ Achieved							Outstanding target to Achieve
					Process Redesign	Corporate Functions	Other Workforce Costs	Procurement Savings	Other	Income	Total	
		£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Central Income												
SaFF income	Lorraine Bewes										0	0
Central Non SaFF income	Lorraine Bewes										0	0
Total Central Income		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Frontline Directorate												
Imaging & Anaesthetics	Kate Hall	0	(602)	(602)	232	0	291	79	0	0	602	0
HIV/GUM	Debbie Richards	(400)	(284)	(684)	23	0	39	271	220	170	723	39
Medicine & A&E	Nicola Hunt	(226)	(1,259)	(1,485)	747	0	49	0	106	18	920	(565)
Surgery	Kate Hall	0	(449)	(449)	371	0	43	78	0	0	492	43
Womens & Children's	Sherryn Elsworth	0	(727)	(727)	711	0	35	0	16	0	762	35
Subtotal Frontline Directorates		**(626)**	**(3,321)**	**(3,947)**	**2,084**	**0**	**457**	**428**	**342**	**188**	**3,499**	**(448)**
Pharmacy	Karen Robertson		(88)	(88)	0	0	67	13	0	8	88	0
Physiotherapy & Occ Therapy	Douline Schoeman	(31)	(98)	(129)	0	0	131	13	0	15	160	31
Dietetics	Helen Stracey	(14)	(15)	(29)	20	0	0	5	0	0	25	(4)
Subtotal Clinical Support		**(45)**	**(201)**	**(246)**	**20**	**0**	**198**	**31**	**0**	**23**	**273**	**27**
Chief Executive	Heather Lawrence		(28)	(28)	0	0	0	0	28	0	28	0
Governance & Corporate Affairs	Cathy Mooney	(19)	(81)	(100)	0	100	0	0	0	0	100	0
Nursing	Andrew MacCallum	(5)	(142)	(147)	0	125	0	22	0	0	147	0
Human Resources	Maxine Foster	(26)	(126)	(152)	0	15	80	41	0	0	136	(16)
Finance	Lorraine Bewes		(259)	(259)	0	96	17	35	0	165	313	54
IM&T & EPR	Alex Geddes	(99)	(261)	(360)	0	139	0	151	0	70	360	0
Occupational Health	Stella Sawyer		(6)	(6)	0	6	0	0	0	0	6	0
Subtotal Management Exec		**(149)**	**(903)**	**(1,052)**	**0**	**481**	**97**	**249**	**28**	**235**	**1,090**	**38**
Facilities	Helen Elkington		(343)	(343)	0	0	0	398	0	180	578	235
Private Patients	Edward Donald		0	0	0	0	0	0	0	0	0	0
ACU	Sherryn Elsworth		0	0	0	0	0	0	0	0	0	0
Post Graduate Centre	Kevin Shotlift		0	0	0	0	0	0	0	0	0	0
Projects	Edward Donald		(21)	(21)	0	0	0	21	0	0	21	(0)
Simulation Centre	Andrew MacCallum		0	0	0	0	0	0	0	0	0	0
Service Level Agreements	Edward Donald		(210)	(210)	0	0	0	125	0	0	125	(85)
Subtotal Other Directorates		**0**	**(574)**	**(574)**	**0**	**0**	**0**	**544**	**0**	**180**	**724**	**150**
Total All Directorates		**(820)**	**(4,999)**	**(5,819)**	**2,104**	**481**	**752**	**1,251**	**370**	**626**	**5,585**	**(234)**
Central Targets												
Capital Charges	Lorraine Bewes	(1,000)	(700)	(1,700)	0	0	0	0	1,907	0	1,907	207
Procurement Savings	Lorraine Bewes		(500)	(500)	0	0	0	273	0	0	273	(227)
Staff Rostering	Edward Donald		(500)	(500)	592	0	0	0	0	0	592	92
Bank and Agency Rates	Maxine Foster		(500)	(500)	0	0	344	0	0	0	344	(156)
Ward Stock Management	Edward Donald		(200)	(200)	0	0	0	0	0	0	0	(200)
HCD Income	Lorraine Bewes		(513)	(513)	0	0	0	0	0	444	444	(69)
GUM Overperformance	Lorraine Bewes		(500)	(500)	0	0	0	0	0	487	487	(13)
Other	Lorraine Bewes	159	(100)	59	0	0	0	300	0	0	300	359
Director's Valuation	Lorraine Bewes		(500)	(500)	0	0	0	0	740	0	740	240
High Cost Drugs	Lorraine Bewes		(400)	(400)	0	0	0	0	0	400	400	0
Total Central Budgets		**(841)**	**(4,413)**	**(5,254)**	**592**	**0**	**344**	**573**	**2,647**	**1,331**	**5,487**	**233**
Net Deficit(-)/Surplus(+)		**(1,661)**	**(9,412)**	**(11,073)**	**2,696**	**481**	**1,096**	**1,825**	**3,016**	**1,957**	**11,072**	**(1)**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST
TRUST WIDE SAVINGS DETAIL INCLUDING PLANS IN DEVELOPMENT
Responsibility: Finance Director

FORM F5B
September 06

Directorate/ Service Area	Accountability	Risk	Total Savings Target	Savings Planned/Achieved							Outst-anding Target
				Process Redesign	Corporate Functions	Other Workforce Costs	Procurement Savings	Other	Income	Total Savings	
			£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Frontline Directorate											
Imaging & Anaesthetics	Kate Hall		(602)								(602)
Capacity plan 04-05		Achieved				291				291	291
Critical Care 1 % savings		Achieved		3						3	3
IMPACT secondment		Achieved		12						12	12
ITU 1% savings		Achieved		22			13			35	35
ITU bed closure		Achieved		46						46	46
Radiology 1% savings		Achieved		43			25			68	68
Theatres 1% savings		Achieved		45			1			46	46
Theatres skill mix		Achieved		41						41	41
Treatment Centre 1% savings		Achieved		20			5			25	25
TSSU 1% savings		Achieved					7			7	7
Urology Non-Pay		Achieved					28			28	28
			(602)	232	0	291	79	0	0	602	0
HIV/GUM	Debbie Richards		(684)								(684)
Contribution from Chlamydia initiative		Achieved							10	10	10
Skill Mix saving - Charing Cross		Achieved		6						6	6
Skill Mix saving - The Ward		Achieved		17						17	17
Viral Load Testing Tender		Achieved					211			211	211
VAT Saving on Home delivery of Drugs		Achieved					40			40	40
VAT Saving on Home delivery of Drugs		Medium					20			20	20
Development Funding		Achieved						155		155	155
New Income targets		Achieved							95	95	95
New Income targets		Medium							66	66	66
Travel Costs		Medium						15		15	15
Non recurring underpends		Medium						50		50	50
Band 6 Saving		Achieved				39				39	39
			(684)	23	0	39	271	220	171	724	40
Medicine & A&E	Nicola Hunt		(1,485)								(1,485)
A&E Floating Locum		High		41						41	41
Close Ward		Achieved		673						673	673
Medicine Floating Locum		High		33						33	33
Sleep Studies		Medium							18	18	18
Thalium Scans		Medium						70		70	70
Rental Of Adele Dixon		Low						36		36	36
Consultant Savings		Medium				25				25	25
Band 2 Nurse		Achieved				24				24	24
			(1,485)	747	0	49	0	106	18	920	(565)
Surgery	Kate Hall		(449)								(449)
Burn- Unit		Achieved					25			25	25
Close Surgical Beds		Achieved		260			45			305	305
Management saving		Achieved					8			8	8
Plastic Medical Staff		Achieved		73						73	73
Restructuring of Admin Support		Achieved		38						38	38
Band 5 and 0.4 A&C 3		Achieved				43				43	43
			(449)	371	0	43	78	0	0	492	43

Directorate/ Service Area	Accountability	Risk	Total Savings Target	Savings Planned/Achieved							Outst-anding Target
				Process Redesign	Corporate Functions	Other Workforce Costs	Procurement Savings	Other	Income	Total Savings	
			£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Womens & Children's	Sherryn Elsworth		(727)								(727)
Staff Savings - Gynae		Achieved		95						95	95
Closing Bay on Annie Zunz at weekends-staff & Non pay		Achieved		58						58	58
Closing Bay on Annie Zunz at weekends-catering		Medium		2						2	2
Additional Colposcopy/Hysteroscopy Income		Medium		67						67	67
Staff Savings - Mgmt		Achieved		20						20	20
Staff Savings - Maternity		Achieved		123						123	123
Skill Mix Savings - NICU		Achieved		34						34	34
Staff Savings - Paed Community		Achieved		65						65	65
Staff Savings - Paeds		Achieved		109						109	109
Closing Jupiter Wards at weekends		Achieved		73						73	73
Closing Jupiter Wards at weekends- catering		Medium		3						3	3
Paediatric Dental Recharge		Achieved						16		16	16
Staff Savings - Women's Medical		Achieved		26						26	26
SHO Rota Change		Achieved		37						37	37
Band 5		Achieved				35				35	35
			(727)	711	0	35	0	16	0	762	35
Subtotal Frontline Directorates			**(3,947)**	**2,084**	**0**	**457**	**428**	**342**	**189**	**3,500**	**(447)**
Pharmacy	Karen Robertson		(88)							0	(88)
0.4 WTE MTO2 reduction		Achieved				12				12	12
A&C 4 1WTE (band3)		Achieved				25				25	25
Books		Achieved					8			8	8
Hammersmith Miscrobiology Income		Achieved							8	8	8
MSSE		Achieved					5			5	5
MT04 Uncovered maternity leave		Achieved				5				5	5
Staff pay 0.3 E grade leave vacant		Achieved				15				15	15
Technical staff		Achieved				10				10	10
			(88)	0	0	67	13	0	8	88	0
Physiotherapy & Occ Therapy	Douline Schoeman		(129)							0	(129)
Income savings		Achieved							15	15	15
Non-pay Savings		Achieved				22	13			35	35
Staff Savings		Achieved				83				83	83
Band 4		Achieved				26				26	26
			(129)	0	0	131	13	0	15	160	31
Dietetics	Helen Stracey		(29)							0	(29)
Non-pay Savings		Achieved					5			5	5
Staff Savings		Achieved		20						20	20
			(29)	20	0	0	5	0	0	25	(4)
Subtotal Clinical Support			**(246)**	**20**	**0**	**198**	**31**	**0**	**23**	**273**	**27**
Chief Executive	Heather Lawrence	Achieved	(28)					28		28	0
Governance & Corporate Affairs	Catherine Mooney		(100)							0	(100)
Clinical Gov Coordinator 1.0 post		Achieved			45					45	45
Clinical Gov Support Officer 1.0 post		Achieved			29					29	29
Consultancy		Achieved			9					9	9
Legal fees		Achieved			18					18	18
			(100)	0	100	0	0	0	0	100	0

Directorate/ Service Area	Accountability	Risk	Total Savings Target	Savings Planned/Achieved							Outst-anding Target
				Process Redesign	Corporate Functions	Other Workforce Costs	Procurement Savings	Other	Income	Total Savings	
			£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Nursing	Andrew MacCallum		(147)							0	(147)
Computer Hardware		Achieved					14			14	14
Staff budget review		Achieved			7					7	7
Lead Nurse Practice & Prof Dev 1.0 WTE		Achieved			47					47	47
Practice Education Facilitator 0.5 WTE		Achieved			48					48	48
Printing & Stationary		Achieved					8			8	8
Vacant Grade 5 post 1.0		Achieved			24					24	24
			(147)	0	125	0	22	0	0	147	0
Human Resources	Maxine Foster		(152)							0	(152)
Consultancy		Achieved				35				35	35
Snr Workforce Info Analyst post		Achieved			15					15	15
Miscellanous Training		Achieved					5			5	5
Play Scheme		Achieved					10			10	10
Reduce Bank opening hours (cost savings)		Achieved				45				45	45
Reduction in Advertising costs		Achieved					17			17	17
Staff recruitment		Achieved					10			10	10
			(152)	0	15	80	41	0	0	136	(16)
Finance	Lorraine Bewes		(259)							0	(259)
Charities Salary Recharges		Achieved							59	59	59
Arrears Charities Salary Recharges		Achieved							15	15	15
Bank Charges		Achieved					5			5	5
Bank Weekly to Monthly Paid		Achieved				17				17	17
CD-rom service reduction		Achieved					12			12	12
Cancellation OFA Software		Achieved					4			4	4
Capitalisation of Capital Accountant (100%)		Achieved			32					32	32
Creditors currrent vacant post		Achieved			24					24	24
Other savings		Achieved			16					16	16
Pharmacy to GL Interface		Achieved			25					25	25
Staff recruitment - use e-recruit		Achieved					14			14	14
Interest Receivable Target		Achieved							91	91	91
			(259)	0	96	17	35	0	165	313	54
IM&T & EPR	Alex Geddes		(360)							0	(360)
Budget for IBM contract		Achieved					68			68	68
IDX		Achieved			134					134	134
Ing Lease for 209 PC's (CHEW01)		Achieved					36			36	36
Lease Cars		Achieved					3			3	3
Legal Fees		Achieved			5					5	5
EPR Savings		Achieved							70	70	70
Software Licences		Achieved					9			9	9
Telephone calls		Achieved					10			10	10
Training		Achieved					22			22	22
Various Leases		Achieved					3			3	3
			(360)	0	139	0	151	0	70	360	(0)
Occupational Health	Stella Sawyer		(6)							0	(6)
Counselling		Medium			6					6	6
			(6)	0	6	0	0	0	0	6	0
Subtotal Management Exec			**(1,052)**	**0**	**481**	**97**	**249**	**28**	**235**	**1,090**	**38**

Directorate/ Service Area	Accountability	Risk	Total Savings Target	Savings Planned/Achieved							Outst-anding Target
				Process Redesign	Corporate Functions	Other Workforce Costs	Procurement Savings	Other	Income	Total Savings	
			£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Facilities	Helen Elkington		(343)							0	(343)
Carparking		Achieved							180	180	180
Franking Machine Mail		Achieved					42			42	42
Interpretation		Achieved					20			20	20
ISS contract terms re: Bed Making		Achieved					24			24	24
ISS Francis Burdette Ward Cleaning		Achieved					44			44	44
ISS General Areas Cleaning		Achieved					18			18	18
ISS Reception Staffing		Achieved					16			16	16
ISS Ward Cleaning		Achieved					34			34	34
LAS contract		Achieved					200			200	200
			(343)	0	0	0	398	0	180	578	235
Projects	Edward Donald		(21)							0	(21)
Sewage & Water		Achieved					2			2	2
Telephone Calls		Achieved					19			19	19
			(21)	0	0	0	21	0	0	21	(0)
Service Level Agreements	Edward Donald		(210)							0	(210)
Pathology Savings		Medium					100			100	100
Viral Load Testing Tender		Achieved					25			25	25
			(210)	0	0	0	125	0	0	125	(85)
											0
Subtotal Other Directorates			**(574)**	**0**	**0**	**0**	**544**	**0**	**180**	**724**	**150**
Total All Directorates			**(5,819)**	**2,104**	**481**	**752**	**1,251**	**370**	**627**	**5,586**	**(233)**
Central Budgets											
Capital Charges	Lorraine Bewes	Achieved	(1,700)					1,907		1,907	207
Procurement Savings	Lorraine Bewes	Achieved	(500)				273			273	(227)
Staff Rostering	Edward Donald	Medium	(500)	592						592	92
Bank and Agency Rates	Maxine Foster	Achieved	(500)			306				306	(194)
Bank and Agency Rates	Maxine Foster	High				38				38	38
Ward Stock Management	Edward Donald	Medium	(200)							0	(200)
HCD Income	Lorraine Bewes	Achieved	(513)						444	444	(69)
GUM Overperformance	Lorraine Bewes	Achieved	(500)						248	248	(252)
GUM Overperformance	Lorraine Bewes	High							239	239	239
Other	Lorraine Bewes	Achieved	59				300			300	359
Director's Valuation	Lorraine Bewes	Achieved	(500)					740		740	240
High Cost Drugs	Lorraine Bewes	Achieved	(400)						400	400	0
			(5,254)	592	0	344	573	2,647	1,331	5,487	233
Total Central Budgets			**(5,254)**	**592**	**0**	**344**	**573**	**2,647**	**1,331**	**5,487**	**233**
Net Deficit(-)/Surplus(+)			**(11,073)**	**2,696**	**481**	**1,096**	**1,825**	**3,016**	**1,958**	**11,073**	**0**

Achieved		1,958	475	1,033	1,705	2,845	1,635	9,652	87%
Low		0	0	0	0	36	0	36	0%
Medium		664	6	25	120	135	84	1,034	9%
High		74	0	38	0	0	239	351	3%
Total		2,696	481	1,096	1,825	3,016	1,958	11,073	100%

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

TRUST WIDE SAVINGS ACHIEVED BY DIRECTORATE

Responsibility: Finance Director

FORM FC
September 06

Directorate/ Service Area	Accountability	2005/06 B/F target	New Target 2006/07	Total Target 2006/07	Total Savings Planned/ Achieved	Outstanding target to Achieve	Phasing 2006/07 of Savings Achieved												Total
							Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	
		£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Central Income																			
SaFF income	Lorraine Bewes				0	0													
Central Non SaFF income	Lorraine Bewes				0	0													
Total Central Income		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Frontline Directorate																			
Imaging & Anaesthetics	Kate Hall	0	(602)	(602)	602	0	53	53	53	49	49	49	49	49	49	49	49	49	602
HIV/GUM	Debbie Richards	(400)	(284)	(684)	723	39	13	13	34	41	37	83	45	46	46	46	47	47	498
Medicine & A&E	Nicola Hunt	(226)	(1,259)	(1,485)	920	(565)	0	63	63	63	63	63	63	63	63	63	63	63	696
Surgery	Kate Hall	0	(449)	(449)	492	43	20	20	76	42	42	42	42	42	42	42	42	42	492
Womens & Children's	Sherryn Elsworth	0	(727)	(727)	762	35	48	53	49	58	62	62	62	62	62	59	58	58	692
Subtotal Frontline Directorates		**(626)**	**(3,321)**	**(3,947)**	**3,499**	**(448)**	**134**	**202**	**276**	**253**	**253**	**299**	**262**	**262**	**262**	**260**	**259**	**259**	**2,979**
Pharmacy	Karen Robertson	0	(88)	(88)	88	0	7	7	7	7	7	7	7	7	7	7	7	7	88
Physiotherapy & Occ Therapy	Douline Schoeman	(31)	(98)	(129)	160	31	24	24	23	11	14	12	9	9	9	9	9	8	160
Dietetics	Helen Stracey	(14)	(15)	(29)	25	(4)	0	0	0	0	0	3	3	3	3	3	3	3	25
Subtotal Clinical Support		**(45)**	**(201)**	**(246)**	**273**	**27**	**31**	**31**	**30**	**19**	**22**	**22**	**20**	**20**	**20**	**20**	**20**	**19**	**273**
Chief Executive	Heather Lawrence	0	(28)	(28)	28	0	2	2	2	2	2	2	2	2	2	2	2	2	28
Governance & Corporate Affairs	Cathy Mooney	(19)	(81)	(100)	100	0	8	8	8	8	8	8	8	8	8	8	8	8	100
Nursing	Andrew MacCallum	(5)	(142)	(147)	147	0	11	11	13	13	13	13	13	13	13	13	13	13	147
Human Resources	Maxine Foster	(26)	(126)	(152)	136	(16)	9	13	13	13	13	13	13	13	13	13	13	13	152
Finance	Lorraine Bewes	0	(259)	(259)	313	54	23	23	23	25	28	28	28	28	28	28	28	28	313
IM&T & EPR	Alex Geddes	(99)	(261)	(360)	360	0	30	30	30	30	30	30	30	30	30	30	30	30	360
Occupational Health	Stella Sawyer	0	(6)	(6)	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Subtotal Management Exec		**(149)**	**(903)**	**(1,052)**	**1,090**	**38**	**83**	**87**	**89**	**90**	**94**	**94**	**94**	**94**	**94**	**94**	**94**	**94**	**1,100**
Facilities	Helen Elkington	0	(343)	(343)	578	235	48	48	48	48	48	48	48	48	48	48	48	48	578
Private Patients	Edward Donald	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ACU	Sherryn Elsworth	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Graduate Centre	Kevin Shotlift	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Projects	Edward Donald	0	(21)	(21)	21	(0)	2	2	2	2	2	2	2	2	2	2	2	2	21
Simulation Centre	Andrew MacCallum	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Service Level Agreements	Edward Donald	0	(210)	(210)	125	(85)	0	0	3	3	3	3	3	3	3	3	3	3	25
Subtotal Other Directorates		**0**	**(574)**	**(574)**	**724**	**150**	**50**	**50**	**52**	**52**	**52**	**52**	**52**	**52**	**52**	**52**	**52**	**52**	**624**
Total All Directorates		**(820)**	**(4,999)**	**(5,819)**	**5,585**	**(234)**	**298**	**370**	**447**	**415**	**421**	**468**	**428**	**428**	**428**	**426**	**425**	**424**	**4,976**
Central Targets																			0
Capital Charges	Lorraine Bewes	(1,000)	(700)	(1,700)	1,907	207	159	159	159	159	159	159	159	159	159	159	159	159	1,907
Procurement Savings	Lorraine Bewes	0	(500)	(500)	273	(227)	23	23	23	23	23	23	23	23	23	23	23	23	273
Staff Rostering	Edward Donald	0	(500)	(500)	592	92	0	0	0	0	0	0	99	99	99	99	99	99	592
Bank and Agency Rates	Maxine Foster	0	(500)	(500)	344	(156)	0	0	0	0	38	38	38	38	38	38	38	38	306
Ward Stock Management	Edward Donald	0	(200)	(200)	0	(200)	0	0	0	0	0	0	0	0	0	0	0	0	0
HCD Income	Lorraine Bewes	0	(513)	(513)	444	(69)	37	37	37	37	37	37	37	37	37	37	37	37	447
GUM Overperformance	Lorraine Bewes	0	(500)	(500)	487	(13)	0	23	23	23	23	23	23	23	23	23	23	23	248
Other	Lorraine Bewes	159	(100)	59	300	359	25	25	25	25	25	25	25	25	25	25	25	25	300
Director's Valuation	Lorraine Bewes	0	(500)	(500)	740	240	62	62	62	62	62	62	62	62	62	62	62	62	741
High Cost Drugs	Lorraine Bewes	0	(400)	(400)	400	0	33	33	33	33	33	33	33	33	33	33	33	33	400
Total Central Budgets		**(841)**	**(4,413)**	**(5,254)**	**5,487**	**233**	**339**	**362**	**362**	**362**	**400**	**400**	**498**	**498**	**498**	**498**	**498**	**498**	**5,214**
Net Deficit(-)/Surplus(+)		**(1,661)**	**(9,412)**	**(11,073)**	**11,072**	**(1)**	**637**	**732**	**809**	**776**	**821**	**867**	**926**	**926**	**927**	**924**	**923**	**923**	**10,189**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

TRUST WIDE SAVINGS ACHIEVED BY DIRECTORATE

Responsibility: Finance Director

FORM F5D
September 06

Directorate/ Service Area	Accountability	Total Target 2006/07	Phasing 2006/07 Planned/Achieved							Phasing 2006/07 Achieved							Variance of M1-M6 Plan to Achieved Over/ (Under)	Var as % of Planned/ Achieved
			Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total		
		£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	%
Central Income																		
SaFF income	Lorraine Bewes																	
Central Non SaFF income	Lorraine Bewes																	
Total Central Income		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Frontline Directorate																		
Imaging & Anaesthetics	Kate Hall	(602)	53	53	53	49	49	49	307	53	53	53	49	49	49	307	0	
HIV/GUM	Debbie Richards	(684)	17	17	38	53	48	103	276	13	13	34	41	37	83	221	(55)	-19.8%
Medicine & A&E	Nicola Hunt	(1,485)	0	71	71	79	79	98	400	0	63	63	63	63	63	316	(84)	-20.9%
Surgery	Kate Hall	(449)	20	20	76	42	42	42	241	20	20	76	42	42	42	241	0	
Womens & Children's	Sherryn Elsworth	(727)	53	59	55	63	68	68	365	48	53	49	58	62	62	331	(34)	-9.2%
Subtotal Frontline Directorates		**(3,947)**	**143**	**220**	**293**	**286**	**286**	**360**	**1,589**	**134**	**202**	**276**	**253**	**253**	**299**	**1,417**	**(172)**	**-10.8%**
Pharmacy	Karen Robertson	(88)	7	7	7	7	7	7	44	7	7	7	7	7	7	44	0	
Physiotherapy & Occ Therapy	Douline Schoeman	(129)	24	24	23	11	14	12	107	24	24	23	11	14	12	107	0	
Dietetics	Helen Stracey	(29)	0	0	0	0	0	3	5	0	0	0	0	0	3	5	0	
Subtotal Clinical Support		**(246)**	**31**	**31**	**30**	**19**	**22**	**22**	**156**	**31**	**31**	**30**	**19**	**22**	**22**	**156**	**0**	**0**
Chief Executive	Heather Lawrence	(28)	2	2	2	2	2	2	14	2	2	2	2	2	2	14	0	
Governance & Corporate Affairs	Cathy Mooney	(100)	8	8	8	8	8	8	50	8	8	8	8	8	8	50	0	
Nursing	Andrew MacCallum	(147)	11	11	13	13	13	13	72	11	11	13	13	13	13	72	0	
Human Resources	Maxine Foster	(152)	9	13	13	13	13	13	74	9	13	13	13	13	13	74	0	
Finance	Lorraine Bewes	(259)	23	23	23	25	28	28	147	23	23	23	25	28	28	147	0	
IM&T & EPR	Alex Geddes	(360)	30	30	30	30	30	30	179	30	30	30	30	30	30	179	0	
Occupational Health	Stella Sawyer	(6)	1	1	1	1	1	1	3	0	0	0	0	0	0	0	(3)	-100.0%
Subtotal Management Exec		**(1,052)**	**84**	**88**	**89**	**91**	**94**	**94**	**539**	**83**	**87**	**89**	**90**	**94**	**94**	**536**	**(3)**	**-0.6%**
Facilities	Helen Elkington	(343)	48	48	48	48	48	48	289	48	48	48	48	48	48	289	0	0.0%
Private Patients	Edward Donald	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
ACU	Sherryn Elsworth	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Post Graduate Centre	Kevin Shotlift	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Projects	Edward Donald	(21)	2	2	2	2	2	2	11	2	2	2	2	2	2	11	0	
Simulation Centre	Andrew MacCallum	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Service Level Agreements	Edward Donald	(210)	8	8	11	11	11	11	60	0	0	3	3	3	3	10	(50)	-83.3%
Subtotal Other Directorates		**(574)**	**58**	**58**	**61**	**61**	**61**	**61**	**360**	**50**	**50**	**52**	**52**	**52**	**52**	**310**	**(50)**	**-13.9%**
Total All Directorates		**(5,819)**	**316**	**397**	**474**	**457**	**463**	**537**	**2,643**	**298**	**370**	**447**	**415**	**421**	**468**	**2,418**	**(225)**	**-8.5%**
Central Targets									0							0	0	
Capital Charges	Lorraine Bewes	(1,700)	159	159	159	159	159	159	954	159	159	159	159	159	159	954	0	
Procurement Savings	Lorraine Bewes	(500)	23	23	23	23	23	23	137	23	23	23	23	23	23	137	0	
Staff Rostering	Edward Donald	(500)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Bank and Agency Rates	Maxine Foster	(500)	0	0	0	38	38	38	115	0	0	0	0	38	38	76	(38)	-33.3%
Ward Stock Management	Edward Donald	(200)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
HCD Income	Lorraine Bewes	(513)	37	37	37	37	37	37	224	37	37	37	37	37	37	224	0	
GUM Overperformance	Lorraine Bewes	(500)	20	42	42	42	42	42	231	0	23	23	23	23	23	113	(119)	-51.3%
Other	Lorraine Bewes	59	25	25	25	25	25	25	150	25	25	25	25	25	25	150	0	
Savings to be worked up									0							0	0	
Director's Valuation	Lorraine Bewes	(500)	62	62	62	62	62	62	370	62	62	62	62	62	62	370	0	
High Cost Drugs	Lorraine Bewes	(400)	33	33	33	33	33	33	200	33	33	33	33	33	33	200	0	
Total Central Budgets		**(5,254)**	**359**	**381**	**381**	**420**	**420**	**420**	**2,380**	**339**	**362**	**362**	**362**	**400**	**400**	**2,223**	**(157)**	**-6.6%**
Net Deficit(-)/Surplus(+)		**(11,073)**	**675**	**778**	**855**	**876**	**882**	**956**	**5,023**	**637**	**732**	**809**	**776**	**821**	**867**	**4,641**	**(382)**	**-7.6%**

Chelsea & Westminster Healthcare NHS Trust

FORM F6

September 06

BALANCE SHEET

Responsibility: Finance Director

	OPENING BALANCE £000	LAST MONTH ACTUAL £000	THIS MONTH ACTUAL £000	YEAR END FORECAST £000
INTANGIBLE FIXED:	0	0	0	0
TANGIBLE FIXED ASSETS :				
Land	46,725	46,725	49,395	50,000
Buildings	208,922	206,049	228,509	209,917
Plant & Equipment	12,347	11,650	14,479	13,038
RELEVANT FIXED ASSETS :	**267,994**	**264,424**	**292,383**	**272,955**
Under Construction	11,924	14,180	7,324	4,370
TOTAL FIXED ASSETS :	**279,918**	**278,604**	**299,707**	**277,325**
CURRENT ASSETS :				
Stocks & Work In Progress	5,237	5,086	6,094	5,493
Trade Debtors	18,490	14,465	14,728	11,972
Provision for Irrecoverable Debt	(8,850)	(7,934)	(9,063)	(1,380)
Accruals and Prepayments	2,938	2,917	2,940	2,300
Other Debtors	4,372	1,456	1,852	1,242
Cash at Bank & in Hand	678	10,649	482	11,706
Short - term Investment	0	0	0	0
TOTAL CURRENT ASSETS :	**22,865**	**26,639**	**17,033**	**31,333**
CURRENT LIABILITIES :				
Tax and social security costs	(2,836)	(2,993)	(3,030)	(2,993)
Dividends Payable	0	(4,029)	0	0
Trade Creditors	(11,302)	(7,861)	(8,141)	(14,326)
Accruals and deferred income	(8,545)	(8,257)	(8,992)	(4,071)
Other Creditors	(1,816)	(4,097)	(5,673)	(5,724)
TOTAL CURRENT LIABILITIES :	**(24,499)**	**(27,237)**	**(25,835)**	**(27,114)**
NET CURRENT ASSETS / (LIABILITIES)	**(1,634)**	**(598)**	**(8,802)**	**4,219**
Creditors over one year	(969)	(969)	(969)	(17,239)
Provisions for liabilities and Charges	(4,554)	(4,411)	(2,213)	(432)
TOTAL ASSET EMPLOYED	**272,761**	**272,626**	**287,723**	**263,873**
CAPITAL & RESERVES				
Public Dividend Capital	168,981	168,981	162,346	163,708
Loans	0	0	0	0
TOTAL CAPITAL DEBT	**168,981**	**168,981**	**162,346**	**163,708**
RESERVES				
Revaluation Reserve	97,085	97,085	118,006	91,675
Donation Reserve	7,194	7,129	7,421	7,489
Other Reserve	0	0	0	0
Income & Expenditure Reserve / (Deficit)	(499)	(568)	(49)	1,001
TOTAL RESERVE	**103,780**	**103,646**	**125,378**	**100,165**
TOTAL CAPITAL AND RESERVES	**272,761**	**272,626**	**287,723**	**263,873**

Chelsea & Westminster Healthcare NHS Trust

FORM F7

September 06

Age Debtor Analysis

Responsibility: Finance Director

September	%Age	Total	Days 0-30	Days 31-90	Days 91+
The Hammersmith Hospitals NHS Trust	**14.48%**	823,284	65,042	15,433	742,809
Surrey PCT	**6.65%**	597,510	261,424	-51,179	387,265
Hammersmith and Fulham Primary Care Trust	**3.95%**	573,807	373,065	128,210	72,532
Adur, Arun And Worthing PCT	**2.76%**	436,547	199,611	66,563	170,374
Royal Brompton & Harefield NHS Trust	**2.53%**	431,616	58,266	67,132	306,218
Brent, Kensington C & W Mental Health Trust	**2.25%**	413,639	0	0	413,639
Westminster PCT	**2.16%**	411,701	45,003	169,974	196,724
Wandsworth NHS Primary Care Trust	**2.10%**	407,646	316,668	5,082	85,896
Western Sussex PCT	**2.00%**	397,807	0	0	397,807
Kensington and Chelsea PCT	**1.98%**	387,672	321,435	0	66,237
Sub Total	**40.86%**	**4,881,230**	**1,640,514**	**401,215**	**2,839,501**
Other Debtors	**59.14%**	9,846,344	3,935,688	0	5,910,656
	100%	**14,727,574**	**5,576,202**	**401,215**	**8,750,157**
% of total		**100.0%**	**37.9%**	**2.7%**	**59.4%**
Increase/(decrease) on last month		**262,478**	**3,027,077**	**-1,754,314**	**-1,010,285**
% Increase/(decrease)on previous month		**1.8%**	**118.7%**	**-81.4%**	**-10.4%**

Analysis of Private Patients Debtors

Outstanding as at 30 September 2006		1,425,235	509,565	208,113	707,557
% of total		**100.0%**	**35.8%**	**14.6%**	**49.6%**
Increase/(decrease) on last month		35,601	90,666	-104,450	49,385
% Increase/(decrease)on previous month		2.6%	21.6%	-33.4%	7.5%

Analysis of Overseas Visitors Debtors

Outstanding as at 30 September 2006		1,224,794	60,885	42,835	1,121,074
		100.0%	**5.0%**	**3.5%**	**91.5%**
Increase/(decrease) on last month		24,572	-16,931	17,211	24,292
% Increase/(decrease)on previous month		2.0%	-21.8%	67.2%	2.2%

August	%Age	Total	Days 0-30	Days 31-90	Days 91+
The Hammersmith Hospitals NHS Trust	**19.25%**	790,652	15,487	46,423	728,743
Adur, Arun And Worthing PCT	**3.24%**	451,371	31,984	84,363	335,024
Royal Brompton & Harefield NHS Trust	**2.79%**	447,312	17,478	122,197	307,638
CNWL Mental Health Trust	**2.78%**	443,402	380,918	0	62,485
Brent, Kensington C & W Mental Health Trust	**2.52%**	413,639	0	0	413,639
Western Sussex PCT	**2.46%**	397,807	0	0	397,807
Hounslow PCT	**2.41%**	395,386	0	186,342	209,044
Westminster PCT	**2.30%**	392,345	21	152,635	239,689
Southend-On-Sea PCT	**2.00%**	362,882	41,084	38,672	283,126
Hammersmith And Fulham Primary Care Trust	**1.96%**	307,455	64,528	0	242,927
Sub Total	**41.71%**	**4,402,253**	**551,499**	**630,631**	**3,220,122**
Other Debtors	**58.29%**	10,062,843	1,997,625	1,524,898	6,540,320
	100%	**14,465,096**	**2,549,125**	**2,155,529**	**9,760,442**
		100.0%	**17.6%**	**14.9%**	**67.5%**

Analysis of Private Patients Debtors

Outstanding as at 31 August 2006		1,389,634	418,898	312,563	658,172
% of total		**100.0%**	**30.1%**	**22.5%**	**47.4%**

Analysis of Overseas Visitors Debtors

Outstanding as at 31 August 2006		1,200,223	77,816	25,625	1,096,782
% of total		**100.0%**	**6.5%**	**2.1%**	**91.4%**

	%age	TOTAL	0 - 30	Days 30 - 90	OVER 90
Opening Balance April 2006-2007	**100.00%**	**18,427,343**	**7,426,985**	**1,205,330**	**9,795,027**
Age Analysis %		**100.0%**	**40.3%**	**6.5%**	**53.2%**

Customer Movement - Top 10	**£**
The Hammersmith Hospitals NHS Trust	32,632
Surrey PCT	597,510
Hammersmith and Fulham Primary Care Trust	266,352
Adur, Arun And Worthing PCT	-14,824
Royal Brompton & Harefield NHS Trust	-15,697
Brent, Kensington C & W Mental Health Trust	0
Westminster PCT	19,356
Wandsworth NHS Primary Care Trust	407,646
Western Sussex PCT	0
Kensington and Chelsea PCT	387,672
Total	**1,680,647**

Chelsea & Westminster Healthcare NHS Trust
Age Creditors Analysis Report & Better Payment Practice Code Month Ended 30 September 2006

FORM F8A
September 06

Responsibility: Finance Director

	CURRENT MONTH: September	**%age of Total Car's**	**TOTAL**	**Days 0 - 30**	**Days 30 - 90**	**Days OVER 90**
	Top 10 Creditor Balances		**£**	**£**	**£**	**£**
1	HAMMERSMITH HOSPITALS NHS TRU	22.01%	1,792,005	154,709	351,192	1,286,104
2	ISS MEDICLEAN LTD.	7.82%	636,510	636,510	0	0
3	HOUNSLOW PRIMARY CARE TRUST..	6.24%	508,302	0	0	508,302
4	IMPERIAL COLLEGE	6.14%	500,028	500,028	0	0
5	WANDSWORTH TEACHING PRIMARY C	5.15%	419,637	397,433	3,538	18,667
6	ST MARYS HOSPITAL NHS TRUST	4.59%	373,536	101,397	77,132	195,007
7	NHS LOGISTICS AUTHORITY	3.73%	303,390	55,373	61,836	186,182
8	HADEN BUILDING MANAGEMENT LTD	3.10%	252,196	90,238	30,852	131,106
9	BRISTOL-MYERS SQUIBB PHARMACE	2.52%	205,385	42,842	33,449	129,093
10	SPECIALIST COMPUTER CENTRES	2.47%	200,712	34,498	0	166,214
	Sub Total	**63.77%**	**5,191,700**	**2,013,027**	**557,999**	**2,620,674**
	Others Creditors	36.23%	2,950,112	2,495,335	196,523	258,254
	TOTAL	**100.00%**	**8,141,812**	**4,508,362**	**754,522**	**2,878,928**
	% of total		**100.00%**	**55.37%**	**9.27%**	**35.36%**
	Incease/decrease on last month		**280,486**	**-181,332**	**-282,016**	**743,834**
	% increase /decrease on last month		**3.57%**	**-3.87%**	**-27.21%**	**34.84%**

	PREVIOUS MONTH : August	**%age of Total Cr's**	**TOTAL**	**Days 0 - 30**	**Days 30 - 90**	**Days OVER 90**
	Top 10 Creditor Balances		**£**	**£**	**£**	**£**
1	HAMMERSMITH HOSPITALS NHS TRU	21.55%	1,694,098	403,247	671,041	619,810
2	HOUNSLOW PRIMARY CARE TRUST..	11.14%	875,526	826,458	21,135	27,932
3	IMPERIAL COLLEGE	6.47%	508,302	0	0	508,302
4	GILEAD SCIENCES LTD.	4.14%	325,480	117,958	12,165	195,357
5	BRISTOL-MYERS SQUIBB PHARMACE	3.86%	303,390	61,836	55,373	186,182
6	MAWDSLEY BROOKS & CO LTD	3.57%	280,443	129,216	20,846	130,381
7	HADEN BUILDING MANAGEMENT LTD	3.31%	260,379	260,379	0	0
8	WANDSWORTH PRIMARY CARE TRUST	3.16%	248,497	211,438	9,192	27,866
9	ST MARYS HOSPITAL NHS TRUST	3.04%	238,858	238,858	0	0
10	ROYAL BROMPTON & HAREFIELD NH	3.03%	238,285	238,285	0	0
	Sub Total	**63.26%**	**4,973,257**	**2,487,674**	**789,752**	**1,695,831**
	Others Creditors	36.74%	2,888,069	2,202,021	246,786	439,262
	TOTAL	**100.00%**	**7,861,326**	**4,689,695**	**1,036,537**	**2,135,093**
	Percentage of No. of days / Total Creditors		**100.00%**	**59.66%**	**13.19%**	**27.16%**

	Opening Balance April 2006 - 2007		11,302,033	5,430,889	507,928	5,363,215
		%age	***100.00%***	***48.05%***	***4.49%***	***47.45%***

Movement from Previous Month

	Supplier	**£**
1	HAMMERSMITH HOSPITALS NHS TRU	97,907
2	GILEAD SCIENCES LTD.	636,510
3	HOUNSLOW PRIMARY CARE TRUST..	0
4	BRISTOL-MYERS SQUIBB PHARMACE	261,170
5	HADEN BUILDING MANAGEMENT LTD	171,141
6	IMPERIAL COLLEGE	48,056
7	WANDSWORTH TEACHING PRIMARY C	0
8	ST MARYS HOSPITAL NHS TRUST	(28,247)
9	ROYAL BROMPTON & HAREFIELD NH	205,385
10	ROYAL BOROUGH OF KENSINGTON &	200,712
	Total	**1,592,633**

BETTER PAYMENT PRACTICE CODE - INVOICES PAID WITHIN 30 DAYS

	This month				**Cummulative**		**Prior year**
	VALUE	**NUMBER**	**%age (Value)**	**%age (No)**	**%age (Value)**	**%age (No)**	**%age (No)**
April	£6,122,327	4,043	91.97%	91.84%	91.97%	91.84%	79.83%
May	£6,501,739	4,064	92.34%	90.63%	92.16%	91.23%	77.50%
June	£8,988,152	5,310	76.07%	93.01%	84.71%	91.93%	89.09%
July	£6,099,298	3,757	78.97%	91.57%	83.37%	91.85%	88.16%
August	£10,015,987	3,620	88.59%	94.37%	84.70%	92.28%	88.39%
September	£8,083,243	4,372	91.92%	94.12%	85.89%	92.59%	71.70%

Chelsea & Westminster Healthcare NHS Trust

Age Creditors Analysis Report & Better Payment P Month Ended 30th October 2006

FORM F8B
September 06

Responsibility: Finance Director

	CURRENT MONTH: August	**%age of Total Cr's**	**TOTAL**	**Days 0 - 30**	**Days 30 - 90**	**Days OVER 90**
	Top 8 NHS Balances & 2 Non Nhs Bal		£	£	£	£
1	HAMMERSMITH HOSPITALS NHS TRU	22.01%	1,792,005	154,709	351,192	1,286,104
2	HOUNSLOW PRIMARY CARE TRUST..	6.24%	508,302	0	0	508,302
3	IMPERIAL COLLEGE	4.59%	373,536	101,397	77,132	195,007
4	WANDSWORTH TEACHING PRIMARY C	3.73%	303,390	55,373	61,836	186,182
5	ST MARYS HOSPITAL NHS TRUST	3.10%	252,196	90,238	30,852	131,106
6	ROYAL BROMPTON & HAREFIELD NH	2.52%	205,385	42,842	33,449	129,093
7	LONDON AMBULANCE SERVICE NHS	1.75%	142,798	71,177	69,201	2,420
8	NHS LOGISTICS AUTHORITY	1.70%	138,058	138,058	0	0
9	ISS MEDICLEAN LTD.	1.24%	101,315	65,589	22,198	13,528
10	SOUTHEND PCT	1.17%	95,494	0	0	95,494
	Sub Total	**48.05%**	**3,912,478**	**719,382**	**645,860**	**2,547,235**
	Others Creditors	51.95%	4,229,334	3,791,095	106,546	331,692
	TOTAL	**100.00%**	**8,141,812**	**4,510,477**	**752,407**	**2,878,928**
	Percentage of No. of days / Total Creditors		**100.00%**	**55.40%**	**9.24%**	**35.36%**

	PREVIOUS MONTH : July	**%age of Total Cr's**	**TOTAL**	**Days 0 - 30**	**Days 30 - 90**	**Days OVER 90**
	Top 8 NHS Balances & 2 Non Nhs Bal		£	£	£	£
1	HAMMERSMITH HOSPITALS NHS TRU	21.55%	1,694,098	403,247	671,041	619,810
2	ISS MEDICLEAN LTD.	11.14%	875,526	826,458	21,135	27,932
3	HOUNSLOW PRIMARY CARE TRUST..	6.47%	508,302	0	0	508,302
4	IMPERIAL COLLEGE	4.14%	325,480	117,958	12,165	195,357
5	WANDSWORTH TEACHING PRIMARY C	3.86%	303,390	61,836	55,373	186,182
6	ST MARYS HOSPITAL NHS TRUST	3.57%	280,443	129,216	20,846	130,381
7	NHS LOGISTICS AUTHORITY	3.31%	260,379	260,379	0	0
8	ROYAL BROMPTON & HAREFIELD NH	2.55%	200,575	47,067	24,822	128,686
9	NHS BLOOD AND TRANSPLANT	1.23%	97,022	82,980	0	14,042
10	SOUTHEND PCT	1.21%	95,494	0	0	95,494
	Sub Total	**59.03%**	**4,640,709**	**1,929,141**	**805,382**	**1,906,186**
	Others Creditors	40.97%	3,220,617	2,760,554	231,156	228,907
	TOTAL	**100.00%**	**7,861,326**	**4,689,695**	**1,036,537**	**2,135,093**
	Percentage of No. of days / Total Creditors		**100.00%**	**59.66%**	**13.19%**	**27.16%**
	Opening Balance April 2006 - 2007		11,302,033	5,430,889	507,928	5,363,215
		%age	**100.00%**	**48.05%**	**4.49%**	**47.45%**

Movement from Previous Month

	Supplier	£
1	HAMMERSMITH HOSPITALS NHS TRU	97,907
2	HOUNSLOW PRIMARY CARE TRUST..	0
3	IMPERIAL COLLEGE	48,056
4	WANDSWORTH TEACHING PRIMARY C	0
5	ST MARYS HOSPITAL NHS TRUST	(28,247)
6	ROYAL BROMPTON & HAREFIELD NH	4,809
7	LONDON AMBULANCE SERVICE NHS	142,798
8	NHS LOGISTICS AUTHORITY	(122,321)
9	ISS MEDICLEAN LTD.	(774,210)
10	SOUTHEND PCT	0

Chelsea and Wesminster Healthcare NHS Trust Cash Flow Statement Responsibility: Finance Director	1	2	3	4	5	6	7	8	9	10	11	12		FORM F9A September 06
£ 000	Actual Apr-06	Actual May-06	Actual Jun-06	Actual Jul-06	Actual Aug-06	Forecast Sep-06	Forecast Oct-06	Forecast Nov-06	Forecast Dec-06	Forecast Jan-07	Forecast Feb-07	Forecast Mar-07	Actual YTD	Forecast Outturn
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Total Operating Surplus/(Deficit)	2,196	(1,537)	1,750	1,445	(172)	1,280	950	950	950	900	889	1,045	4,962	10,646
Depreciation and Amortisation	838	746	792	466	714	714	708	709	709	709	709	697	4,270	8,511
Transfer from the donated asset reserve	(20)	(6)	(13)	(13)	(13)	(13)	(13)	(13)	(13)	(13)	(13)	(13)	(78)	(156)
(Increase)/Decrease in Stocks	639	133	(504)	24	555	(1,007)	24	24	24	24	24	(216)	(160)	(256)
(Increase)/Decrease in Debtors	(237)	3,316	1,215	1,162	(25)	446	587	300	768	(584)	(582)	(1,153)	5,877	5,213
Increase/(Decrease) in Creditors	8,830	(4,394)	(2,648)	(82)	(1,892)	2,627	(313)	(464)	(465)	(566)	(416)	(723)	2,441	(506)
Increase/(Decrease) in Provisions	(85)	73	(553)	(241)	660	(2,198)	(388)	(388)	(388)	(388)	(2)	(295)	(2,344)	(4,193)
OPERATING ACTIVITIES														
Net cash inflow(outflow) from operating activities	**12,161**	**(1,669)**	**39**	**2,761**	**(173)**	**1,849**	**1,555**	**1,118**	**1,585**	**82**	**609**	**(658)**	**14,968**	**19,259**
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:														
Interest received	55	51	60	35	56	48	45	45	60	60	60	25	305	600
Interest paid	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interest element of finance leases	0	0	0	0	0	0	0	0	0	0	0	(80)	0	(80)
Net cash inflow/(outflow) from returns on investments and servicing of finance	**55**	**51**	**60**	**35**	**56**	**48**	**45**	**45**	**60**	**60**	**60**	**(55)**	**305**	**520**
CAPITAL EXPENDITURE														
Payments to acquire tangible fixed assets	0	(104)	(927)	(1,345)	(1,029)	(596)	(890)	(469)	(779)	(854)	(970)	(455)	(4,001)	(8,418)
Donations	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net cash inflow (outflow) from capital expenditure	**0**	**(104)**	**(927)**	**(1,345)**	**(1,029)**	**(596)**	**(890)**	**(469)**	**(779)**	**(854)**	**(970)**	**(455)**	**(4,001)**	**(8,418)**
DIVIDENDS PAID	0	0	0	0	0	(4,833)	0	0	0	0	0	(4,833)	(4,833)	(9,666)
Net cash inflow/(outflow) before management of liquid resources and financing	**12,216**	**(1,722)**	**(828)**	**1,451**	**(1,146)**	**(3,532)**	**710**	**694**	**866**	**(712)**	**(301)**	**(6,001)**	**6,439**	**1,695**
MANAGEMENT OF LIQUID RESOURCES	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net cash inflow (outflow) from management of liquid resources	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Net cash inflow (outflow) before financing	**12,216**	**(1,722)**	**(828)**	**1,451**	**(1,146)**	**(3,532)**	**710**	**694**	**866**	**(712)**	**(301)**	**(6,001)**	**6,439**	**1,695**
FINANCING														
Public dividend capital received	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Public dividend capital repaid	0	0	0	0	0	(6,635)	0	0	0	0	0	0	(6,635)	(6,635)
Department of Health -PACS - Brokerage	0	0	0	0	0	0	0	1,000	0	0	0	0	0	1,000
Capital Allocation - PACS	0	0	0	0	0	0	0	962	0	0	0	0	0	962
Capital element of finance lease rental payments	0	0	0	0	0	0	0	0	0	0	0	(38)	0	(38)
DOH - Loan for 2 yrs (Interest at the Public Loans Boards rate)	0	0	0	0	0	0	6,250	0	0	0	0	0	0	6,250
Foundation Trust Financing Facility	0	0	0	0	0	0	2,143	0	0	2,774	0	2,877	0	7,794
Brokerage payments and receipts	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net cash inflow (outflow) from financing	**0**	**0**	**0**	**0**	**0**	**(6,635)**	**8,393**	**1,962**	**0**	**2,774**	**0**	**2,839**	**(6,635)**	**9,333**
Increase (decrease) in cash	**12,216**	**(1,722)**	**(828)**	**1,451**	**(1,146)**	**(10,167)**	**9,103**	**2,656**	**866**	**2,062**	**(301)**	**(3,162)**	**(196)**	**11,028**
Opening Cash Balance	**678**	**12,894**	**11,172**	**10,344**	**11,795**	**10,649**	**482**	**9,585**	**12,241**	**13,107**	**15,169**	**14,868**	**678**	**678**
Cash Balance at the end of the period	**12,894**	**11,172**	**10,344**	**11,795**	**10,649**	**482**	**9,585**	**12,241**	**13,107**	**15,169**	**14,868**	**11,706**	**482**	**11,706**

FORM F9B
September 06

Chelsea & Westminster Healthcare NHS Trust
ANALYSIS OF CASH FUNDS MOVEMENT
Responsibility: Finance Director

NORMAL ACTIVITIES	April	May	June	July	August	September	October	November	December	January	February	March	TOTAL
	Actual	Actual	Actual	Actual	Actual	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
RECEIPTS	29,493	17,449	21,427	22,545	25,429	20,986	21,700	20,829	20,829	20,829	20,829	22,487	264,832
PAYMENTS	(17,277)	(19,171)	(22,255)	(21,094)	(26,575)	(24,518)	(20,990)	(20,135)	(19,963)	(21,541)	(21,130)	(28,488)	(263,137)
NET MOVEMENT	12,216	(1,722)	(828)	1,451	(1,146)	(3,532)	710	694	866	(712)	(301)	(6,001)	1,695
Cumulative	12,216	10,494	9,666	11,117	9,971	6,439	7,149	7,843	8,709	7,997	7,696	1,695	
FUNDING / BROKERAGE	0	0	0	0	0	(6,635)	8,393	1,962	0	2,774	0	2,839	0
NET MOVEMENT	0	0	0	0	0	(6,635)	8,393	1,962	0	2,774	0	2,839	0
Cumulative	0	0	0	0	0	(6,635)	1,758	3,720	3,720	6,494	6,494	9,333	
TOTAL FUND MOVEMENT	12,211	(1,722)	(828)	1,451	(1,146)	(10,167)	9,103	2,656	866	2,062	(301)	(3,162)	1,691
Cumulative	12,216	10,494	9,666	11,117	9,971	(196)	8,907	11,563	12,429	14,491	14,190	11,028	

SUMMARY OF CUMULATIVE MOVEMENTS	April	May	June	July	August	September	October	November	December	January	February	March	
NORMAL ACTIVITIES													
Forecast	3,123	8,737	9,635	9,767	10,108	6,447	7,149	7,843	8,709	7,997	7,696	1,695	
Actual	12,216	10,494	9,666	11,117	9,971	6,439	0	0	0	0	0	0	
FUNDING / BROKERAGE													
Forecast	0	0	0	0	0	2,762	1,758	3,720	3,720	6,494	6,494	9,333	
Actual	0	0	0	0	0	(6,635)	0	0	0	0	0	0	
COMBINED													
Forecast	3,123	8,737	9,635	9,767	10,108	9,209	8,907	11,563	12,429	14,491	14,190	11,028	
Actual	12,211	10,494	9,666	11,117	9,971	(196)	0	0	0	0	0	0	

CHELSEA AND WESTMINSTER HEALTHCARE NHS TRUST
FINANCIAL PERFORMANCE RETURNS
CAPITAL PROGRAMME 2006/2007
ACTUAL SPEND AND FORECAST OUT-TURN AS AT 30th SEPTEMBER 2006

	Planned Spend 2006/2007	Expenditure to date	Forecast Out-turn	(Over)/Under Spend
	£000	£000	£000	£000
SUMMARY				
A. SCHEMES CARRIED FORWARD FROM 05/06	936.0	900.0	936.0	36.0
B. APPROVED SCHEMES MORE THAN ONE YEAR	2,353.0	549.0	2,353.0	1,804.0
C. BACK LOG MAINTENANCE	740.0	263.0	740.0	477.0
D. ENVIRONMENTAL	220.0	21.0	220.0	199.0
E. DEVELOPMENT WORKS	452.0	81.0	452.0	371.0
F. SPECIAL PROJECT	1,370.0	72.0	1,370.0	1,298.0
G. IT EQUIPMENT	834.0	540.0	834.0	294.0
H. MEDICAL EQUIPMENT	1,338.0	116.0	1,338.0	1,222.0
I . SCHEMES PRESENTED DURING THE YEAR	2,376.0	211.0	2,376.0	2,165.0
J. CONTINGENCY	52.0	-	52.0	52.0
K. DONATED	-	7.0	-	(7.0)
L. OTHERS	-	88.0	-	(88.0)
CAPITAL PROGRAMME TOTAL	**10,671.0**	**2,848.0**	**10,671.0**	**7,823.0**

FUNDING			
CAPITAL RESOURCE LIMIT - FUNDING RECEIVED			
BLOCK ALLOCATION	7,999.0		
CARRIED FORWARD	1,373.0		
BROKERAGE REVERSAL 05/06	(4,393.0)		
OLD CAPITAL BROKERAGE CONVERTED TO PERMANENT PDC	3,480.0		
SHA LOAN FOR PACS	1,000.0		
CONNECTING FOR HEALTH PACS FUNDING	962.0		
TOTAL CRL	**10,421.0**		**-**

DONATED			
DONATED	-	-	-

DONATED FUNDING	**-**
TOTAL FUNDING	**10,421.0**
PROGRAMME (OVER)/UNDER SPEND	**(250.0)**

Chelsea & Westminster Healthcare NHS Trust

Provision for Aged Debtors

Responsibility: Finance Director

FORM F11
September 06

Customer	Amount	% of Total Debtors	Current	Overdue by 1-30 Days	Overdue by 31-60 Days	Overdue by 61-90 Days	Overdue by 91-180 Days	Overdue by 181-360 Days	Overdue by 361+ Days	Provisions
NHS Bodies	10,717,374	72.77%	4,403,362	0	0	42,771	1,288,606	679,766	4,302,869	(6,685,414)
NHS Other	40,721	0.28%	13,116	3,717	3,515	470	3,779	2,105	14,020	
Private Patients - Self Funding	228,810	1.55%	88,581	22,694	38,733	12,756	28,888	37,158	0	(70,000)
Private Patients - Insurance Companies	1,087,732	7.39%	404,938	66,937	78,236	57,026	160,541	145,488	174,567	(400,000)
Private Patients - Maternity	56,683	0.38%	0	0	0	0	0	0	56,683	
Private Patients - ACU	48,059	0.33%	14,626	0	804	5,065	11,319	9,905	6,342	(30,000)
Private Patients - Overseas	1,224,794	8.32%	60,885	13,899	28,936	6,655	34,222	124,110	956,086	(1,028,357)
Private Patients - Doctors & Consultants	3,950	0.03%	1,420	320	390	150	1,080	590	0	
Default	167,423	1.14%	154,604	0	153	452	119	2,684	9,411	0
Other General Trading Organisations	1,152,589	7.83%	213,501	18,419	22,672	28,833	267,295	100,544	501,326	(848,819)
Private Patients - PCT	(562)	0.00%	(562)	0	0	0	0	0	0	
Grand Total:	**14,727,574**	**100.00%**	**5,354,471**	**125,985**	**173,439**	**154,178**	**1,795,848**	**1,102,351**	**6,021,303**	**(9,062,590)**

Provisions Cover	94,121	138,760	1,706,056	1,102,351	6,021,303	**9,062,590**
% of Provision Cover	**54.27%**	**90.00%**	**95.00%**	**100.00%**	**100.00%**	**(0)**

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 23rd November 2006

AGENDA ITEM NO.	3.5/Nov/06
PAPER	Performance Report – September 2006
AUTHOR	Nicolas Cabon, Head of Performance and Information
LEAD	Lorraine Bewes, Director of Finance and Information
SUMMARY	This report presents the information on the Trust's performance to the end of September 2006.
DECISION/ ACTION	The Council is asked to note this report.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

PERFORMANCE REPORT FOR THE PERIOD APRIL - SEPTEMBER 2006

1.0 PURPOSE

1.1 The purpose of this report is to provide information about the Trust's performance from April to September 2006. The Trust Board is asked to note the report and conclusions.

2.0 CONTENT AND DEVELOPMENT OF PERFORMANCE REPORT

2.1 The report comprises of the following components:

- **Board Dashboard – pg 6**
- **Analysis of Breaches of Targets – pg 7**
- **Activity Summary – pg 8**
- **HR Summary – pg 9**
- **SLA Performance Summary – pg 10**
- **Efficiency and Resources Summary – pg 11**
- **Access – pg 11**
- **18 Week Journey – pg 12**

2.2 The Healthcare Commission has published the existing national indicators that will be assessed during 2006/07. However we are awaiting minor updates to the new national indicators, the commission has stated that publication is imminent; for these indicators we will predict a threshold. This report also includes analysis of performance against the 18 week Referral to Treatment target.

3.0 SUMMARY

3.1 The Trust is on track to meet 13 of the existing and new external indicators set by the Healthcare Commission.

3.2 The Trust is predicting a banding of 'Not Met' for the indicators of Cancer patients waiting 62 days for treatment, Thrombolysis and MRSA.

3.3 The Trust is predicting a banding of 'Almost Met' for the indicators of Data Quality on Ethnic Group and MRI & CT waiting times.

3.4 The internal indicators show that Deaths following selected surgical procedures and patient complaints are not currently meeting required standards.

3.5 Variances in activity against plan can be seen in elective inpatients (9.2% above), emergency inpatient spells (11% below), and non-elective spells (21.3% above).

3.6 Overall, the Trust is performing well against the new to follow up ratio target.

3.7 The recording of outpatient outcomes is significantly below the target.

3.8 The Trust day case rate is improving gradually and is currently 1.1% below target.

3.9 Average elective inpatient length of stay is performing better than target while average non-elective inpatient length of stay is significantly above target.

3.10 Diagnoses per episode remains 0.23 below the Trust target of 2.25.

3.11 HR Indicators show that bank and agency usage has reduced, as has vacancy rates, unplanned turnover and sickness rates.

3.12 Overall the Trust is £21k below plan on SLA performance monitoring. The key contributing areas to this are elective admissions, non-elective admissions, A&E Attendances and other activity such as additional over-performance targets.

4.0 EXTERNAL HEALTHCARE COMMISSION TARGETS – page 6 and 7

4.1 The dashboard highlights the Trust position against key Healthcare Commission targets and internal indicators. There are four possible outcomes for the targets, for existing targets these are Fully Met, Almost Met, Partly Met or Not Met and for new targets they are Excellent, Good, Fair and Weak.

4.2 The Trust is on schedule to fully meet nine of the existing targets and to be rated as excellent for four of the new targets; however there are three existing targets that are forecast to be rated as Not Met. These targets relate to Cancer patients waiting 62 days from GP referral to first treatment, Thrombolysis, and MRSA. The Trust's performance is forecast to be rated as Almost Met for the indicators on Data Quality on Ethnic Group and MRI & CT waiting times.

4.3 **CANCER WAITS:** Year to date there have been 37 patients treated for cancer of which 34.5 were treated within 62 days of their GP referral. 2 breaches occurred during May and 0.5 during August, there have been no further breaches since, suggesting extra measures put in place are effective. Where the treatment of a patient is provided jointly by two trusts this is recorded 0.5 patients each.

4.4 **THROMBOLYSIS:** With a total of 6 eligible cases year to date it is growing increasingly unlikely that the Trust will be rated on this indicator during 2006/07, as we would require 20 eligible cases for assessment.

4.5 **MRSA:** There was 1 MRSA case in the Trust during September. This brings the total for the year to 14, which is 17% above the trajectory. The Trust can only afford to have 9 further cases in the final half of the year.

4.6 The Trust is also monitoring the rate of C difficile. The rate so far this year is 0.88 per 1000 bed days, compared with a rate of 1.56 in the calendar year 2005.

4.7 **ETHNIC CATEGORY CODING:** Significant improvement has been made in this area in the past few months, and the Trust is very close to its target of 95%. This indicator has become more significant this year as the Healthcare Commission has indicated that it will carry out a national review of service provision to black and minority ethnic groups in 2006/7. The importance of recording all of the patients' demographic details correctly will continue to be a focus of attention for the Data Quality Group, and further plans will be devised to achieve the few percentage points that are required to meet the target.

4.8 **MRI & CT WAITING TIMES**: We are predicting a reduction in the waiting times for this indicator from 26 weeks to 13 weeks. If the Commission apply the same thresholds as 2005/06 then the Trust is currently 0.6% below the threshold to fully meet this indicator.

5.0 INTERNAL INDICATORS – page 6

5.1 The Trust is on track to achieve all of the internal indicators with the exception of Deaths following Selected Non-Elective Surgical Procedures and Patient Complaints. There have been 16 deaths so far this year, a performance rating of 1.7% year to date compared with a target of 1%. Details of each death have been sent to the relevant directorate for investigation. Performance of patient complaints being responded to within 20 days has

fallen over the past few months to just below the 90% target (89%). This area is likely to be included in one of the Healthcare Commissions national reviews during 2006/07.

6.0 ACTIVITY SUMMARY – page 8

6.1 The activity summary shows the levels of activity of the Trust compared with the same period last year and also against the year to date capacity plan.

6.2 Growth in referrals has slowed a little during September. Compared with the corresponding period last year GP referrals are currently 12% higher and Other referrals are 9% higher. These figures are derived from the QM08 outpatient waiting time report. The accuracy of this report has been questioned and is still being investigated.

6.3 New outpatient attendances year to date are increasing at a rate that is 2% greater than was predicted in the capacity plan. A corresponding decrease has been seen in follow-up attendances which are 2% lower than planned. This reflects the Trust's work in reducing the new to follow-up rate in accordance with the plan and suggestions from PCTs.

6.4 The over performance in elective inpatient activity continues to slow to 9% greater than plan compared with 10% at month five. Day case spells are 1% greater than plan.

6.5 The underperformance in emergency spells has improved from 14% below plan at month five to 11% below plan at month six. Non-elective spells remain 21% higher than plan. Of this increase the number of maternity delivery spells was 51% greater than expected in the plan similar to the position last month.

6.6 A&E attendances continue at a greater rate than the same period last year however adult attendances are 4% above plan and paediatric attendances are 14% lower than the plan year to date.

7.0 EFFICIENCY AND RESOURCES – page 9

7.1 The efficiency and use of resources summary shows how well the Trust is performing against targets that were derived from the capacity plan, Dr Foster national averages, CHKS benchmarks or the average Trust performance for the previous year.

7.2 The Trust continues to meet the overall new to follow-up rate for outpatients; however, the year to date rates for the Surgery and W&C directorates are significantly above their respective targets. The plan for each PCT has been set at specialty level. Therefore, income will be at risk if we do not achieve the individual specialty target – we may not be allowed to offset good performance in one specialty against missing the target for a different specialty.

7.3 The number of outpatient attendances with an outcome recorded has risen to a year to date position of 73.7%. However, this is significantly below the Trust target of 100%.

7.4 The average elective length of stay remains below the target set for the Trust. While the average non-elective length of stay continues to reduce and is now 3.81 days at the end of month six, however this is still much higher than the target of 3.18 days.

7.5 The Trust's day case rate has remained constant during month six and stands at 71.9%; this is marginally below the target of 73%

7.6 The percentage of elective inpatients admitted on the day of surgery continues to rise gradually but is 18% year to date below the Trust target of 81.9%. Some work is required to validate recorded procedure dates which may improve this figure.

7.7 Clinical coding remains a concern for the organisation. While the backlog of coding has reduced there is still 33% of quarter two activity to be coded. The backlog was exacerbated

by a high rate of sick leave during June and July. The depth of coding remained at an average of 2.02 codes per episode against a target of 2.25, suggesting that more work is required in this area.

8.0 HR INDICATORS – page 9

8.1 The HR summary shows key workforce information in relation to numbers of staff, bank and agency usage, sickness, turnover and vacancy rates.

8.2 The staff headcount reduced slightly during September and WTE increased, both are higher than the same period last year. The vacancy rate continues to drop to 13.6%.

8.3 Bank and agency usage continued to fall during September with average bank usage per month approximately 19 WTEs less than last year and agency usage equating to a reduction of just over 27 WTEs.

8.4 Sickness Rates were marginally higher for the first half of the year compared with the same period last year. In 2005/06 the position at month six was 3.31% and for 2006/07 it is 3.53%.

8.5 Unplanned turnover is consistently lower than 2005/06 even though it rose to 1.3% during September, compared with 0.9% during August.

9.0 SLA PERFORMANCE – page 10

9.1 The SLA performance summary shows the year-to-date income and activity performance against commissioned plans, along with a year end forecast.

9.2 The Trust's SLA income is behind plan by c£21k after the first five months of the year and the year end forecast is a deficit of c£818k. The areas causing the deficit include elective activity (day cases, elective admissions and elective excess bed days), non-elective activity, A&E attendances, MFF and additional over-performance targets for Drugs, NICU and GUM. This is also the case for year end forecast variances.

9.3 Whilst A & E attendances are above plan the case mix currently recorded is less complex than expected. This has resulted in income being well below the plan. A review is underway to ensure that all tests/investigations that are carried out are recorded on the Lastword system, the expectation is that this will increase the case mix complexity and result in higher income future months.

9.4 The deficit in elective activity is predominantly seen in Hammersmith and Fulham PCT and more distant PCTs, at Directorate level the deficits are seen across all areas with the exception of HIV. For day case it is entirely due to the HIV Consortium and the HIV/GUM directorate. The Trust has subsequently renegotiated the HIV contract realigning activity plans to reflect actual activity to the end of quarter 1. The variances against the HIV contract are therefore transitional and it is expected that from month 6 the revised plan will be closely mirror the actual activity.

9.5 For non-electives whilst the Trust is ahead of plan for non-elective excess bed days it is behind plan for activity. This deficit in activity affects all directorates bar HIV/GUM and Women and Children's and all PCTs with the exception of Hammersmith and Fulham PCT.

9.6 Critical care for both adult & child services is significantly ahead of plan this is due to increase cot capacity and an increase local PCTs activity and fewer non contracted patients.

9.7 Outpatient follow-up activity is ahead of target for each of the local PCTs except Kensington and Chelsea. The PCTs have applied cap to the follow-up rate for the year, the year end forecast assumes that activity above the agreed ratio will not be recoverable.

10.0 CONCLUSION

10.1 Performance improved marginally during September with no further breaches of the Cancer patient 62 days wait indicator and only 1 MRSA case during the month. Overall the Trust is on track to achieve nearly all of the national targets.

10.2 SLA performance moved favourably in month to £21k below plan for the first five months of the year; however the full year forecast position is a deficit of c£818k.

10.3 Average non-elective length of stay remains significantly higher than plan, and the level of outcomes recorded for outpatient attendances are poor.

Nick Cabon
Head of Performance and Information
25th October 2006

Dashboard of Indicators to Month 6

Exisiting Indicators

Indicator Name	Year to Date	Target	Expected Performance	Trend
All cancers: two week wait	100%	98%		⇔
Cancer patients waiting 31 days from decision to treat to first treatment	99%	98%		⇔
Cancer patients waiting 62 days from GP referral to first treatment	93%	95%		⇔
Cancelled operations	0.43%	0.50%		⇔
Financial management	348k surplus	2.4m surplus		↑
Outpatient and elective (inpatient and daycase) booking	100%	100%		⇔
Delayed transfers of care	2.02%	3.50%		⇔
Elective patients waiting longer than the standard	0.00%	0.03%		⇔
Outpatients waiting longer than the standard	0.01%	0.03%		⇔
Thrombolysis	33%	68%		↑
Total time in A&E: four hours or less	98.4%	98.0%		⇔
Waiting times for rapid access chest pain clinic	100%	99%		⇔

New Indicators

Indicator Name	Year to Date	Target	Expected Performance	Trend
Access to GUM Clinics	75%	60%		↑
Data quality on ethnic group	92%	95%		↑
Emergency Bed Days	-4%	Reduction		↑
Infant Health - Data Completeness	99%	85%		⇔
MRSA	14 cases	12 cases		⇔
Participation in Audits (MINAP)	100%	90%		⇔
Waiting times for MRI or CT scans	99.1%	99.5%		↓

Other Indicators

Indicator Name	Year to Date	Target	Expected Performance	Trend
Clinical risk management	Level 2	Level 2		⇔
Hospital Cleanliness	93%	60%		⇔
Better Hospital Foods	91%	60%		↑
4 hour wait for emergency admission via A&E (trolley waits)	99%	99%		⇔
Deaths following selected elective surgical procedures	1.7%	1.0%		↓
Emergency readmissions following discharge (adults)	11.2%	11.4%		↓
Emergency readmissions following discharge for fractured hip	4.4%	8.6%		⇔
C Difficile Rate (per 1000 bed days)	0.88	tbc		
Information governance toolkit	85%	70%		⇔
Patient complaints	89%	90%		↓

Key

The Trust is on track to meet this target	
The Trust is slightly off track towards this target	
It does not seem likely that the Trust will meet this target.	
It is not possible to accurately assess performance in this area.	
Performance in this indicator is improving.	↑
There is no significant change in performance in this indicator.	⇔
Performance in this indicator is getting worse.	↓

Analysis of Breaches

Breaches of the Cancer Targets		
Month	**No. of Breaches**	**Breach Reason**
May-06	2	2 x 62 day breaches. One in Urology as the patient was brought back after each diagnostic test to be told their results and book the next test. One in Colorectal was routinely booked into diagnostic tests, therefore delays in diagnosing and medical assessment for fitness for surgery.
Jun-06	1	1 x 31 day breach in Urology, patient was originally booked within 31 days but then cancelled as a long day case had to be booked in on that day.
Aug-06	1	0.5 x 62 day breach in Urology. Delay from the patient being seen and referral being made to St Mary's receiving the referral and also elective capacity for robotic prostectomies at St Mary's.

Breaches of the Thrombolysis Target		
Month	**No. of Breaches**	**Breach Reason**
Apr-06	1	1 patient Call to Needle time >60min, as Call to Hospital time = 46min.
May-06	1	1 patient Call to Needle time >60min. Call to needle time 98 minutes, Call to Hospital time = 63 minutes.
Jun-06	3	3 patients Call to Needle time >60 min, 1 patient Call to Hospital time = 76 mins (comment from LAS "difficult entry to patient's housing block"), 1 patient Call to Hospital time = 64 mins, 1 patient Door to Needle time = 39 mins due to delays in the process.

Breaches of the Outpatient Waiting Time Target		
Month	**No. of Breaches**	**Breach Reason**
May-06	1	Dermatology patient - referral letter was misfiled after prioritisation and not added to the pend list. The incident is to be reviewed through the serious untoward incident process.

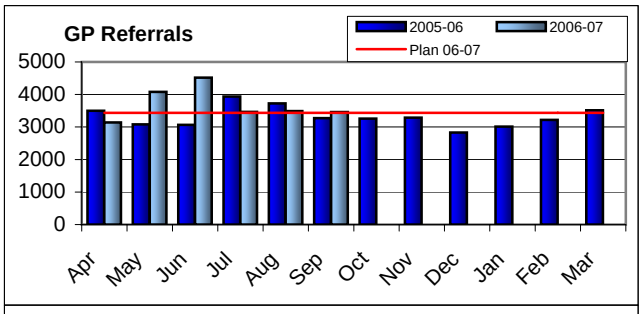
Breaches of the MRSA Target		
Month	**No. of Breaches**	**Breach Reason**
Apr-06	4	3 hospital acquired cases 1 of which was CVC associated, 1 was an infected hickman line and 1 was MRSA Pneumonia. 1 community acquired case in A&E.
May-06	2	2 community acquired cases through A&E.
Jun-06	1	1 hospital acquired case, arterial line.
Jul-06	5	2 hospital acquired cases 1 of which was CVC/Burn associated and 1 was possible femoral line or chest focus. 3 community acquired cases on ICU, Nell Gwynne and A&E.
Aug-06	1	1 community acquired case.
Sep-06	1	1- LWIG/ICU – Probable Hickman Line associated

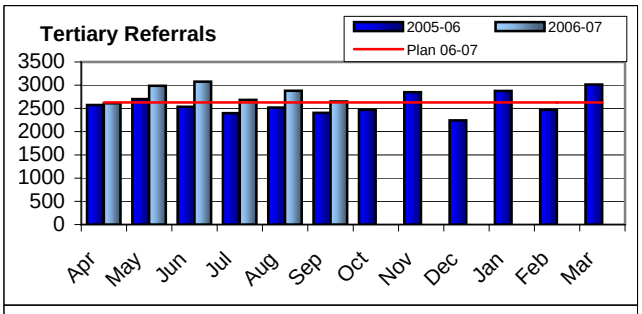
Analysis of Breaches

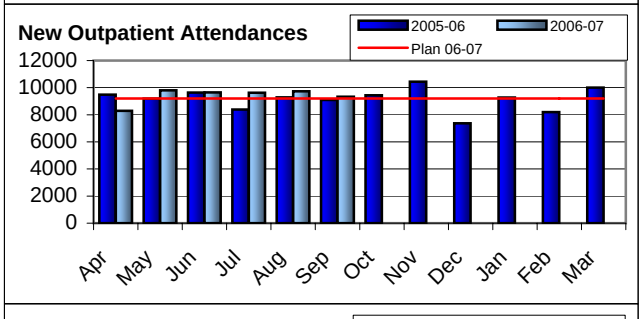
Breaches of the Patient Complaints Target		
Month	**No. of Breaches**	**Breach Reason**
Aug-06	1	1686 - Pain Clinic (A & I). Due out 15/8. Drafted on day due out sent to KH [GM] for sign-off plus copy to me. Patient Advisers needed clarification on an issue and got back to KH and SC. KH liaised with SC and requested amendments to response, which were done. Signed-off copy sent to complaints on 16/8, final draft completed that day and sent over for signing.
Aug-06	1	1687 - Pain Clinic (A & I). Due out on 16/8 drafted by SC just within the timescale, however KH not happy with response and asked SC to make amendments. Signed-off by KH 17/8, final draft done by Patient Adviser 18/8 (Friday) went over for signing on the Monday 21/8.
Aug-06	1	1679 - Surgery. Due out on 7/8. There was a delay in getting a response from a consultant which was received on the day response due out. Response drafted that day by LG however KH not in the office to sign-off. Was signed-off and forwarded to complaints on 8/8 and was sent out on 9/8.
Aug-06	1	1691 - Surgery. This is still open. LG (AGM) was initially having problems in obtaining a response from a consultant who mainly works in St Mary's but does sessions here. She got the notes couriered over to him but felt the response that came back was not satisfactory. Holding letter sent n 16/8. Since then chased response verbally on a number of occasions and also in an e-mail to KH and LG on 29/8
Sep-06	1	1710 - Medicine. Required directorate review to inform complaint response. This took place on 25th Sept, awaiting response.
Sep-06	1	1734 - Medicine. Delay in receiving response from Consultant.
Sep-06	1	1780 - Medicine. Response received after 20 day period.
Sep-06	1	1731 -CSS. Response returned from CE office requiring amendment.
Sep-06	1	1720 - Surgery. Due out 15th September, sent out on 21st September. Response sent at 6pm on 15th September, not received until Monday 18th September.
Sep-06	1	1722 - Surgery. Due out 4th September 2006, still outstanding. Medical Records were temporarily missing therefore consultant could not write a response to the issues raised. The records were finally located on 25th September and a response is now being formulated.
Sep-06	1	1724 - Surgery. Due out 8th September 2006, still outstanding. The response received from the consultant involved was not acceptable. Directorate Manager and Clinical Director are meeting with the consultant to go through he complaint and formulate an acceptable response.
Sep-06	1	1732 - Surgery. Due out 15th September 2006C, still outstanding. Consultant reviewed the notes and needed to speak with other consultants involved in the patient's care, including a surgeon at Charing X who has been on annual leave. This has now happened and a response will be sent out by end of week.
Sep-06	1	1726 - W&C. Due out 12th September. Response received just on time, however this was insufficient and had to be returned to the Directorate for further investigation. Response sent on 18th September 2006.

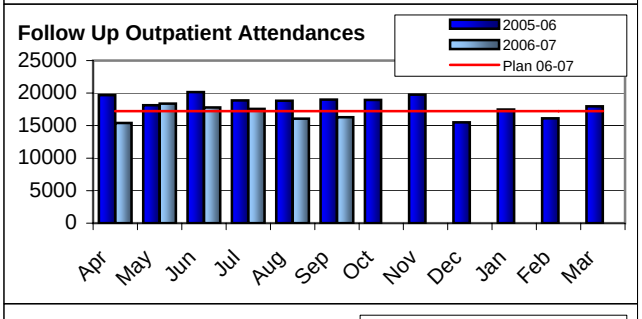
Activity Performance to Month 6

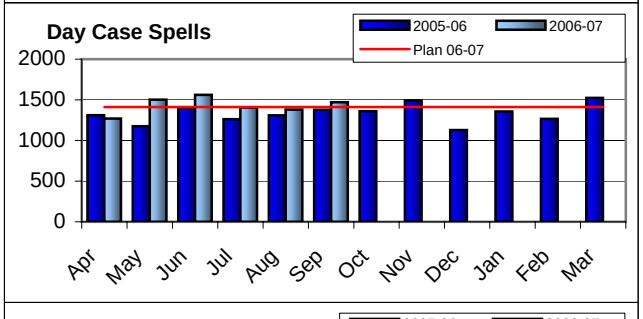
Points of Delivery	Actual Sep 05	Actual Sep 06	Actual to M6 2005/06	Actual to M6 2006/07	Capacity Plan to M6 2006/07	Variance on plan
GP Referrals	3273	3460	20577	22150	19850	11.6%
Other Referrals	2403	2650	15129	16889	15525	8.8%
New Outpatient Attendances	9092	9330	55060	56434	55177	2.3%
Follow Up Outpatient Attendances	19004	16291	114687	101519	103392	-1.8%
Day Case Spells	1378	1471	7829	8589	8469	1.4%
Elective Inpatient Spells	626	545	3574	3356	3072	9.2%
Emergency Spells	1824	1409	9643	8575	9632	-11.0%
Non-Elective Spells	1642	2225	10178	12983	10703	21.3%
A&E Attendances	7514	7935	46634	49098	50113	-2.0%

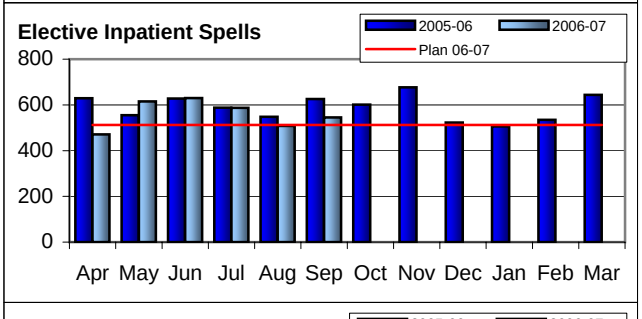


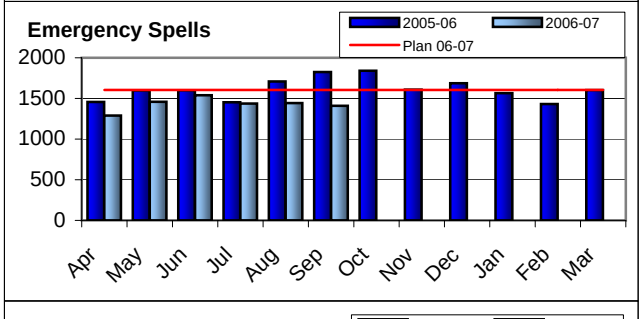


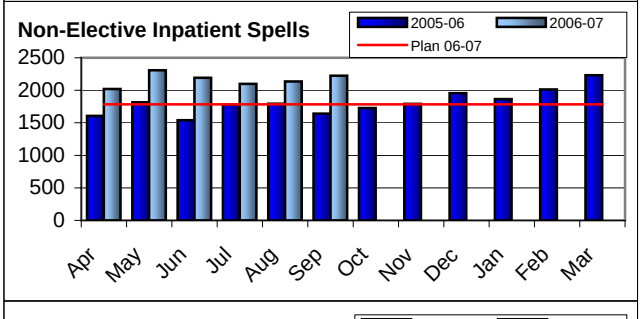


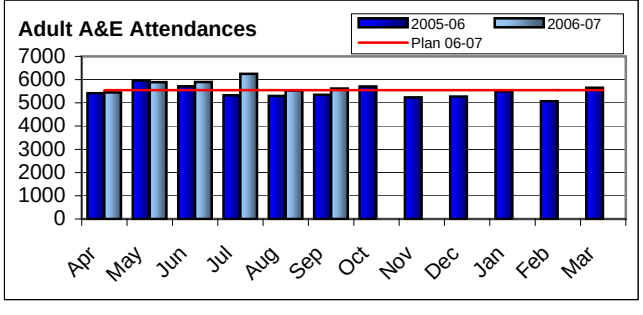


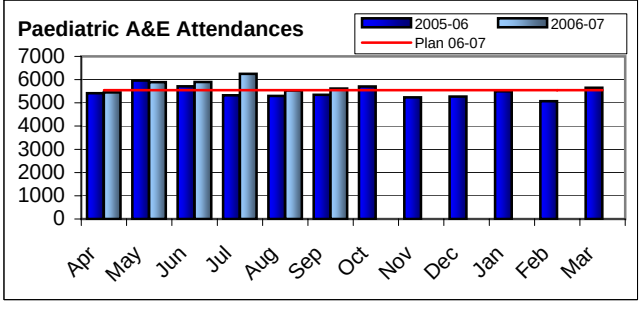






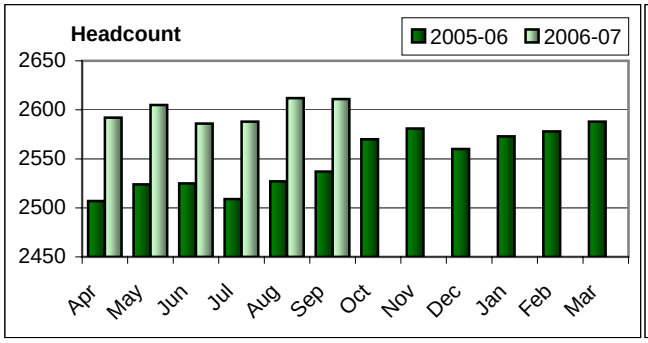


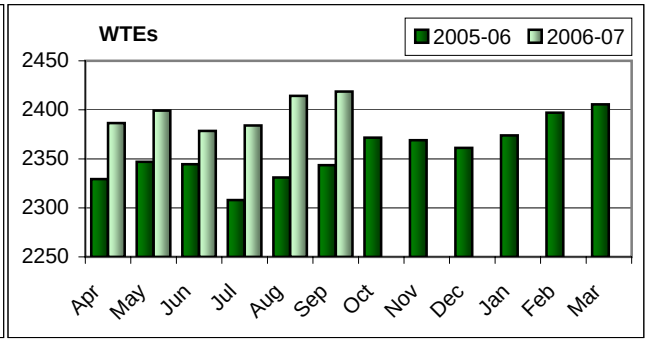


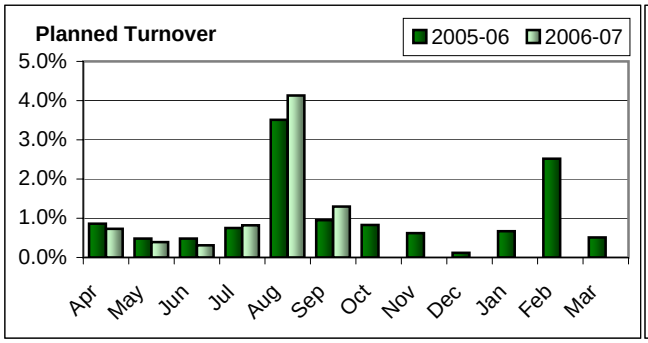


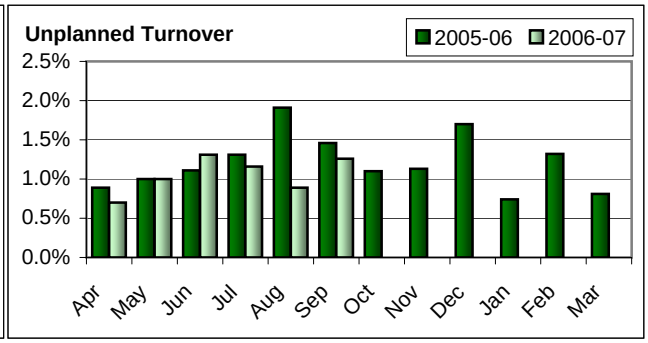
Workforce Performance to Month 6

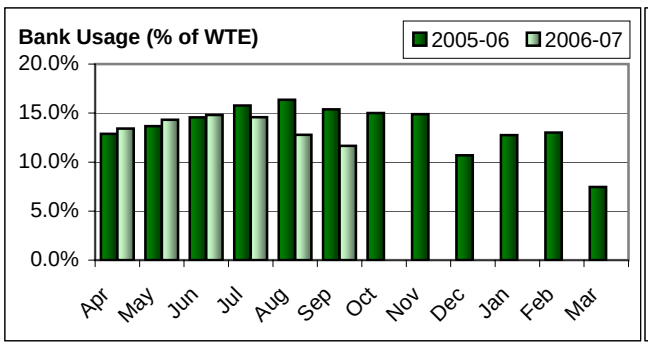
Indicator Name	Sep-05	Sep-06	Variance	Ave M1-M6 2005/06	Ave M1-M6 2006/07	Variance
Headcount	2537	2611	74	2521.5	2599	77.5
Whole Time Equivalents (WTEs)	2343.6	2418.7	75.1	2333.9	2396.9	63.0
Bank Staff (WTEs)	360.3	282.1	-78.2	344.6	325.7	-18.9
Agency Staff (WTEs)	60.4	52.0	-8.4	88.3	61.0	-27.3
Planned Staff Turnover (%)	1.0	1.3	0.4	0.6	1.0	0.3
Unplanned Staff Turnover (%)	1.5	1.3	-0.2	1.3	1.1	-0.2
Vacancy Rate	15.1%	12.8%	-2.4%	15.1%	13.6%	-1.5%
Sickness (%)	3.44	3.49	0.05	3.31	3.53	0.21

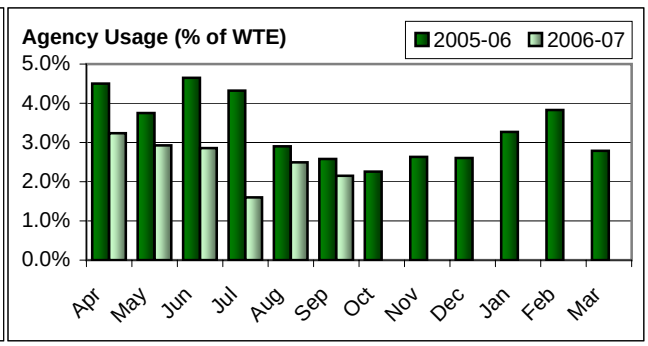


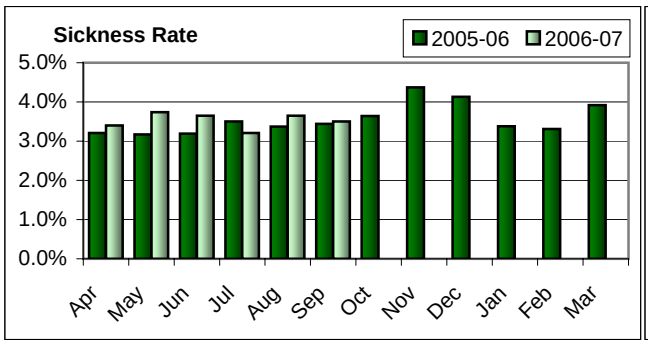


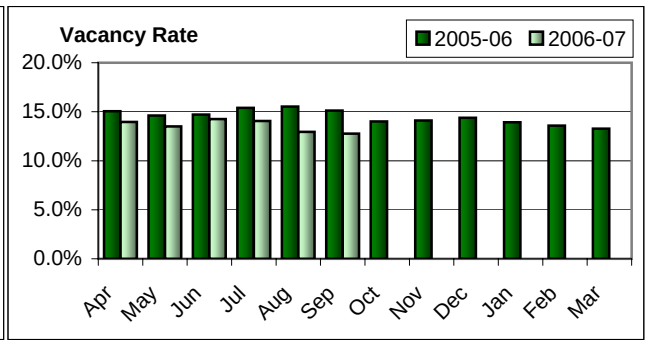












SLA Performance to Month 5

Points of Delivery	Activity to M5	Plan to M5	Variance	Activity to M5 £	Plan to M5 £	Variance £	FY 2006-07 Price plan	2006/07 forecast price actual after provision	FY 2006-07 Forecast variance
New Outpatient Attendances	43909	44250	341	£22,861,969	£22,973,574	£111,605	£54,868,726	£55,136,577	£267,852
Follow Up Outpatient Attendances	82427	88723	6295	£5,525,795	£5,947,371	£421,576	£13,002,094	£13,163,515	£161,421
Elective Inpatient Spells	2987	3123	136	£4,654,548	£4,260,527	-£394,021	£11,170,914	£9,797,818	-£1,373,097
Elective Inpatient Excess Bed Days	2321	1890	-431	£489,706	£443,951	-£45,755	£1,175,295	£1,065,483	-£109,812
Day Case Spells	7552	7366	-186	£5,443,304	£5,335,967	-£107,337	£13,063,929	£12,806,321	-£257,609
Non-Elective Spells	9686	10432	745	£14,488,216	£14,279,396	-£208,820	£34,771,718	£35,738,582	£966,864
Non-Elective Excess Bed Days	6317	6539	223	£1,344,429	£1,395,126	£50,697	£3,226,630	£3,348,303	£121,673
Critical Care (Bed/Cot Days)	6480	7357	877	£4,035,776	£5,085,169	£1,049,393	£9,685,863	£12,301,482	£2,615,619
A&E Attendances	43175	43305	130	£3,407,977	£2,903,838	-£504,140	£8,179,146	£7,705,036	-£474,110
Ward Attenders	1544	634	-910	£133,907	£97,082	-£36,825	£321,377	£232,997	-£88,380
Regular Day Attenders	1361	2045	684	£275,457	£414,815	£139,358	£661,097	£995,557	£334,460
Other	87130	87130	0	£4,690,915	£4,194,183	-£496,731	£11,279,210	£8,296,057	-£2,983,153
Total	**294889**	**302793**	**7904**	**£67,352,000**	**£67,331,000**	**-£21,000**	**£161,406,001**	**£160,587,728**	**-£818,272**

Efficiency and Use of Resources to Month 6

	Indicator Name	2005/06	2005/06 to M6	2006/07 to M6	M6	Target
Admissions	Day Case Rate	68.6%	68.7%	71.9%	73.0%	73.0%
	Basket Procedures Day Case Rate (to M4 due to coding)	62.5%	76.0%	62.4%	57.3%	n/a
	Day of Surgery Admissions	48.9%	42.0%	64.1%	67.3%	81.9%
	Failed Day Cases	3.7%	3.1%	3.8%	3.5%	3.7%
	Midnight Bed Occupancy Rate	90.0%	91.3%	84.5%	84.9%	81.0%

	Indicator Name	2005/06	2005/06 to M6	2006/07 to M6	M6	Target
LoS	Total Inpatient Average Length of Stay	4.25	4.47	3.67	3.48	3.19
	Elective Inpatient Average Length of Stay	3.65	3.90	3.00	2.73	3.21
	Non-Elective Inpatient Average Length of Stay	4.40	4.62	3.81	3.64	3.18
	Pre-operative Length of Stay	1.08	1.10	0.82	0.68	tbc
	Elective Inpatients with a 0 Length of Stay	1029	458	658	78	tbc

	Indicator Name	2005/06	2005/06 to M6	2006/07 to M6	M6	Target
Outpatients	New to Follow Up Rate	2.01	2.08	1.80	1.75	1.94
	Outpatient DNA Rate	13.2%	13.3%	12.9%	12.9%	tbc
	Indicator Name	**2006/07 M4**	**2006/07 M5**	**2006/07 M6**	**Var. M5-M6**	**Target**
	Outpatient Outcomes	65.3%	69.7%	73.3%	3.6%	100.0%

	Indicator Name	2005/06	2006/07 to M6	M6
Theatres	Theatre Session Utilisation	88.9%	89.1%	90.2%
	Theatre Time Utilisation	86.7%	89.1%	90.3%
	Theatre Cases per List	2.67	2.69	2.85

	Indicator Name	2005/06	2005/06 to M6	2006/07 to M6	M6	Target
Other	HES Data Quality Indicator	96.0%	n/a	95.3%	n/a	96.9%
	Diagnoses per Episode	2.15	2.20	2.02	2.13	2.25
	Patient Complaints (to M5 due to coding)	89%	85%	89%	81%	90%

Access to Month 6

	Indicator Name	2005/06	2005/06 to M6	2006/07 to M6	M6
Access	Booked Admissions	87.2%	84.8%	89.8%	89.7%
	Book Additions to the Waiting List	97.3%	95.9%	99.9%	100.0%
	Elective Patients Attending Pre-operative Assessment	56.1%	48.8%	61.8%	53.2%
	Waiting List Removals Other Than Treatment	4016	2145	2075	471

	Indicator Name	M4	M5	M6	Avg. 2006/07
	Waiting List Suspensions (as % of waiting list)	12%	13%	13%	12%
	Waiting List Suspensions > 3 months (as % of suspensions)	47%	42%	44%	52%

Analysis of 18 Week Journey - Q1 2006/7

Specialty Description	Total Elective Admissions	RTT < 18 weeks	% with RTT < 18 weeks	RTT > 18 Weeks	% with RTT > 18 weeks	Unable to Calculate RTT	% Unable to Calculate RTT
General surgery	328	45	14%	121	37%	162	49%
Urology	444	18	4%	30	7%	396	89%
Trauma & Orthopaedics	448	36	8%	114	25%	298	67%
ENT	89	7	8%	39	44%	43	48%
Ophthalmology	166	5	3%	59	36%	102	61%
Oral surgery	1	0	0%	0	0%	1	100%
Plastic surgery	767	8	1%	63	8%	696	91%
General medicine	178	0	0%	0	0%	178	100%
Gastroenterology	121	0	0%	0	0%	121	100%
Cardiology	7	0	0%	0	0%	7	100%
Dermatology	19	0	0%	0	0%	19	100%
Neurology	115	0	0%	0	0%	115	100%
Rheumatology	146	0	0%	0	0%	146	100%
Paediatrics	236	6	3%	10	4%	220	93%
Gynaecology	473	42	9%	136	29%	295	62%
Other	2510	40	2%	80	3%	2390	95%
Total	**6048**	**207**	**3%**	**652**	**11%**	**5189**	**86%**

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 23rd November 2006

AGENDA ITEM NO.	3.6/Nov/06
PAPER	Senior Independent Director
AUTHOR	Fleur Hansen, Foundation Trust Lead
LEAD	Juggy Pandit, Chair
SUMMARY	In accordance with the Monitor Code of Governance (A.3.3), it was recommended that the Board appoint an independent non-executive director to be the Senior Independent Director. The Board appointed Mr Charles Wilson to this role.
DECISION/ ACTION	The Members' Council is asked to note the appointment of Mr Charles Wilson as the Senior Independent Director.

SENIOR INDEPENDENT DIRECTOR

1.0 INTRODUCTION

This paper details Monitor's suggestions regarding the appointment of a Senior Independent Director (SID).

2.0 BACKGROUND

The Monitor Code of Governance published in September this year recommends that Foundation Trusts appoint an independent non-executive director to be the Senior Independent Director. The Trust has not specified this appointment in its Constitution as the Code of Governance was not published until after the Trust's Constitution had been submitted.

3.0 ROLE OF THE SID

According to the Code of Governance, the SID's role is to act as an independent point of contact for not only the Board of Directors but also the Members' Council. The SID should be available to both members and members' councillors if they have concerns which consultation through the normal channels of chairman, chief executive or the finance director have failed to resolve or are inappropriate contacts. The SID is also a point of contact for the Monitor on issues relating to the chairman.

The Code of Governance also recommends that the SID should lead at least one meeting a year of the non-executive directors without the chairman present to appraise the chairman's performance and discuss other issues as appropriate.

Monitor recommends the SID act as a 'point person' for other non-executives and council members to raise concerns and to help resolve conflicts.

4.0 CHARACTERISTICS OF A SID

Bill Moyes from Monitor suggested some characteristics of a SID at the Foundation Trust Network's recent conference on the Code of Governance. He suggested that the SID be confident, visible and diplomatic.

Bill Moyes also emphasised the importance of independence – as such the SID could not be an academic or other partnership representative.

5.0 DECISION/ACTION REQUIRED

The Members' Council is asked to note the appointment of Mr Charles Wilson as the Senior Independent Director.

Fleur Hansen
Foundation Trust Lead
13th November 2006

Members' Council Meeting, 23rd November 2006

AGENDA ITEM NO.	3.8/Nov/06
PAPER	Disability Equality Scheme
AUTHOR	Amanda Pritchard, Director of Integrated Service Delivery and Modernisation & Deputy Chief Executive Maxine Foster, Director of Human Resources
LEAD EXECUTIVE	Amanda Pritchard, Director of Integrated Service Delivery and Modernisation & Deputy Chief Executive
EXECUTIVE SUMMARY	The Disability Discrimination Act 1995 makes it unlawful to discriminate against disabled people. New provisions incorporated into the DDA 2005 include the removal of the requirements to show that a mental impairment is clinically well recognised, brining the definition more in line with that of physical impairment. Additional changes extend the definition of disability to include HIV, multiple sclerosis and cancer at the point of diagnosis. From 4th December 2006, the Act also introduces the duty for public authorities to actively promote equality of opportunity for disabled people and to produce a disability equality scheme (DES). Amongst other things, the disability equality scheme must include an action plan outlining how the organisation intends to promote disability equality and mainstream it into all of its functions and policies. This paper contains a proposed list of overarching strategies to improve access and inclusion for people with disabilities at the Trust and a draft action plan containing more detailed plans.
DECISION/ ACTION	The Members Council is asked to comment on the draft strategies and action plan. The Members Council is also asked to nominate a representative or representatives to join the Trust's Disability Committee.

Disability Equality Scheme

1. Introduction

The Disability Discrimination Act 1995 makes it unlawful to discriminate against disabled people (or people who have had a disability) in several areas, including employment, access to good, facilities and services; education; and transport.

New provisions incorporated into the DDA 2005 include the removal of the requirements to show that a mental impairment is clinically well recognised, brining the definition more in line with that of physical impairment. Additional changes extend the definition of disability to include HIV, multiple sclerosis and cancer at the point of diagnosis.

From 4th December 2006, the Act also introduces the duty for public authorities to actively promote equality of opportunity for disabled people.

Under the General Disability Equality Duty, NHS organisations will have to:

- Promote equality of opportunity between disabled people and other people
- Eliminate discrimination that is unlawful under the Act
- Eliminate harassment of disabled people that is related to their disability
- Promote positive attitudes towards disabled people
- Encourage participation by disabled people in public life
- Take steps to take account of disabled people's disabilities, even where that involves treating them more favourably than other people.

Alongside the general duty outlined above, organisations will also have a specific duty to produce a disability equality scheme (DES). Amongst other things, the disability equality scheme must include an action plan outlining how the organisation intends to promote disability equality and mainstream it into all of its functions and policies.

This paper contains a proposed list of overarching strategies to improve access and inclusion for people with disabilities at the Trust and a draft action plan containing more detailed plans.

The Members Council is asked to comment on the draft strategies and action plan.
The Members Council is also asked to nominate a representative or representatives to join the Trust's Disability Committee.

2. Strategies Towards Disability Equality

The following overarching strategies to improve access to Trust services, buildings and information from 2006-2009 are proposed. They have driven the identification of specific tasks, as reflected in the draft Action Plan. The six desired outcomes provide a framework for improving access and inclusion for people with disabilities at the Trust.

Outcome 1: People with disabilities have the same opportunities as other people to access the services of, and any events organised by, Chelsea and Westminster Hospital NHS Foundation Trust.

	Strategy	**Timeline**
1a	Establish a Disability Equality Committee to guide the implementation of Disability Equality Scheme (DES) activities.	December 2006
1b	Ensure that people with disabilities are provided with an opportunity to comment on access to services.	June 2007
1c	Monitor the Trust's DES to ensure it supports equitable access to services by people with disabilities throughout the various functions of the Trust.	December 2007
1d	Develop links between the DES and other Trust plans and strategies.	June 2008
1e	Ensure that events are organised so that they are accessible to people with disabilities.	June 2007
1f	Ensure that Trust staff and agents and contractors are aware of the relevant requirements of the Disability Discrimination Act.	June 2008

Outcome 2: People with disabilities have the same opportunities as other people to gain employment and promotion at Chelsea and Westminster Hospital NHS Foundation Trust.

	Strategy	**Timeline**
2a	Ensure that recruitment policies and practices take account of the specific needs of disabled people.	December 2006
2b	Ensure that reasonable adjustments are made to ensure disabled staff are not substantially disadvantaged.	December 2006

Outcome 3: People with disabilities have the same opportunities as other people to access the buildings and other facilities of the Trust.

	Strategy	Timeline
3a	Ensure that all buildings and facilities are physically accessible to people with disabilities.	June 2007
3b	Ensure that all new or redevelopment works provide access to people with disabilities, where practicable.	June 2007
3c	Ensure that all premises and other infrastructure related to transport facilities are accessible.	June 2007
3d	Ensure that parking facilities meet the needs of people with disabilities in terms of quantity and location.	June 2007
3e	Ensure that public toilets meet accessibility standards.	June 2007

Outcome 4: People with disabilities receive information from the Trust in a format that will enable them to access the information as readily as other people are able to access it.

	Strategy	Timeline
4a	Improve community awareness that Trust information is available in alternative formats upon request.	January 2007
4b	Improve staff awareness of accessible information needs and how to obtain information in other formats.	June 2007
4c	Investigate and facilitate the use of interpreters to improve the availability of Trust meetings to people with a hearing impairment.	June 2008
4d	Ensure that the Trust's website meets contemporary good practice.	June 2007
4e	Provide documentation regarding services, facilities and customer feedback in an appropriate format using clear and concise language.	December 2007

Outcome 5: People with disabilities receive the same level and quality of service from the staff of the Trust as other people receive.

	Strategy	Timeline
5a	Improve staff awareness of disability and access issues and improve skills to provide a good service to people with disabilities.	June 2008
5b	Improve the awareness of new employees and new Members about disability and access issues.	June 2008
5c	Further generate and sustain staff awareness of disability and access issues.	June 2008
5d	Carry out impact assessments on all existing and new Trust policies and procedures that are relevant to disabled people to ensure that they do not disadvantage disabled people.	June 2008

Outcome 6: People with disabilities have the same opportunities as other people to make complaints to Trust and that staff with disabilities have the same opportunities to raise a grievance.

	Strategy	Timeline
6a	Ensure that current grievance/complaints mechanisms are accessible for people with disabilities.	June 2007
6b	Improve staff knowledge so they can receive complaints from people with a disability.	June 2008
6c	Ensure that grievance/complaints mechanism processes and outcome satisfaction survey forms are available in formats to meet the needs of people with disabilities.	August 2008

Outcome 7: People with disabilities have the same opportunities as other people to participate in public consultation by the Trust.

	Strategy	Timeline
7a	Improve community awareness about consultation processes in place.	June 2007
7b	Commit to ongoing monitoring of the DES to ensure implementation and satisfactory outcomes.	December 2007
7c	Improve access for people with disabilities to the established consultative processes of the trust.	December 2007
7d	Seek a broad range of views on disability and access issues from the local community.	April 2007

3. Action Plan

The Implementation Plan itemises what the Trust will do in 2006-2007 to improve access to its services, information and facilities for people with disabilities.

The Implementation Plan is presented using a table to outline:

- individual tasks being undertaken;
- a timeline for completion of the individual tasks;
- the managerial position or section of the Trust with responsibility for completing the individual tasks; and
- the broad strategy that the individual tasks are supporting.

Many of the broad strategies will not be fully delivered in 2006-2007, however individual tasks to support the achievement of those strategies may well be undertaken in part or whole in 2006-2007 through the Implementation Plan.

Broad strategies that will not be achieved in 2006-2007 will be supported by tasks outlined in future Implementation Plans.

	Strategy	Task	Task Timeline	Responsibility
1a	Establish a Disability Committee to guide the implementation of DES activities.	• Head of Equality and Diversity (to be appointed) to draft a proposal (including terms of reference, meeting schedule, membership) for the establishment of a Disability Committee. • Publicise the Committee and call for members to participate.	December 2006	Head of Equality and Diversity
1b	Ensure that people with disabilities are provided with an opportunity to comment on access to services.	• Head of Equality and Diversity to develop a strategy for ongoing engagement with disabled staff, patients and voluntary sector groups. • Disability Committee to develop a mechanism for gathering ongoing feedback on services from people with disabilities. • Evaluators to include a mechanism to assist people with disabilities to comment on services in future reviews of services.	April 2007 April 2007 June 2007 and ongoing	Head of Equality and Diversity
1c	Monitor the Trust's DES to ensure it supports equitable access to services by people with disabilities throughout the various functions of the Trust.	• Use data, including feedback from staff, patients and the public to monitor the implementation of the action plan and impact of actions taken. • Publish findings and develop the DES in response.	Dec 2007	Disability Committee
1d	Develop links between the DES and other Trust plans and strategies.	• Identify appropriate strategic business planning documents, budget processes and all other relevant plans and strategies requiring alignment with the DES. • Incorporate the objectives of the DES into Trust's strategic business planning, budgeting processes and all other relevant plans and strategies (for completion by June 2008).	June 2008	Head of Equality and Diversity
1e	Ensure that events are organised so that they are accessible to people with disabilities.	• Ensure all events are planned using an Accessible Events checklist. • Make an Accessible Events checklist available to staff on the Trust's Intranet.	June 2007	TBC
1f	Ensure that Trust staff and agents and contractors are aware of the relevant requirements of the DDA	• Promote the Trust's policy and procedures regarding the Disability Discrimination Act's requirements around agents and contractors through Trust News and the induction process for new employees.	June 2008	TBC

	Strategy	Task	Task Timeline	Responsibility
2a	Ensure that recruitment policies and practices take account of the specific needs of disabled people.	• Audit recruitment policies and practices to ensure they take account of the specific needs of disabled people. • Canvas views from disabled people applying for jobs to ensure the process did not disadvantage them. • Review data on the number of disabled applicants vs successful appointments and consider what more (if anything) needs to be done to increase the percentage of disabled people successfully gaining employment/promotion.	December 2006 May 2007 Dec 2007	HR Director
2b	Ensure that reasonable adjustments are made to ensure disabled staff are not substantially disadvantaged.	• Consult disabled staff and occupational health to confirm whether reasonable adjustments are being made.	December 2006	HR Director

	Strategy	Task	Task Timeline	Responsibility
3a	Ensure that all buildings and facilities are physically accessible to people with disabilities.	• Audit and identify access barriers to buildings and facilities using widely accepted Access Resource Kit checklists and Disability Access Consultants. • Identify access complaints to support audit results. • Prioritise and begin work on rectifying identified barriers	April 2007 May 2007 June 2007	GM for Estates and Facilities
3b	Ensure that all new or redevelopment works provide access to people with disabilities.	• Implement procedures to enable the Disability committee to review proposals for redevelopment and new work projects. • Ensure key employees maintain an awareness of the development of the DDA provisions for access goods and services (include appropriate specifications in tender documents).	June 2007	GM for Estates and Facilities
3c	Ensure that all premises and other infrastructure related to transport facilities are accessible.	• Audit all transport infrastructure against the DDA Transport Standards. • Liaise with the relevant Local Authority to ensure co-ordinated planning of remedial works. • Prioritise and make submission to Council to commence work on rectifying identified barriers.	April 2007 May 2007 June 2007	GM for Estates and Facilities
3d	Ensure that parking facilities meet the needs of people with disabilities in terms of quantity and location.	• Undertake an audit of accessible parking bays and implement a program to rectify any non compliance. • Consider the need for additional bays at some locations.	January 2007 June 2007	GM for Estates and Facilities
3e	Ensure that public toilets meet accessibility standards.	• Conduct audit of all public toilets. • Implement a program of upgrading to ensure there is a unisex accessible facility at each location.	April 2007 June 2007	GM for Estates and Facilities

	Strategy	Task	Task Timeline	Responsibility
4a	Improve community awareness that Trust information is available in alternative formats upon request.	• Ensure all documents carry a notation regarding availability in alternative formats. • Advise the community via the local media and disability group newsletters that other formats are available.	Jan 2007 Jan 2007	Head of Communications
4b	Improve staff awareness of accessible information needs and how to obtain information in other formats.	• Develop an Accessible Information policy. • Make the DRC Access Guidelines for Information, Services and Facilities available on the intranet. • Conduct Accessible Information training and include as part of the induction of new employees.	June 2007 June 2007 June 2007	Head of Comms Head of Comms HR Director
4c	Investigate and facilitate the use of interpreters / hearing loops to improve the availability of Trust meetings to people with a hearing impairment.	• Investigate the requirement for interpreters / hearing loops for Trust meetings • Arrange for access to interpreters / fitting of hearing loops as required.	Dec 2007 June 2008	
4d	Ensure that the Trust's website meets contemporary good practice.	• Redevelop website according to the DRC Accessibility guidelines. • Ensure that forms and applications are available electronically.	June 2007 October 2007	ICT Director
4e	Provide documentation regarding services, facilities and customer feedback in an appropriate format using clear and concise language.	• Advise employees of the minimum requirements. • Develop an audit plan (to guide an audit to be undertaken in December 2007), to identify information for people with disabilities who use and/or work in the Trust. • Adopt Disability Rights Commission Guidelines for Information, Services and Facilities, and incorporate into general practice.	Dec 2006 May 2007 Dec 2007	Head of Equality & Diversity via Disability Committee

	Strategy	Task	Task Timeline	Responsibility
5a	Improve staff awareness of disability and access issues and improve skills to provide a good service to people with disabilities.	• Conduct a survey of all employees to determine training needs (training to be undertaken by June 2007). • Provide training on Deafness Awareness and the use of BSL Interpreters.	Dec 2007	HR Director
5b	Improve the awareness of new employees and new Members about disability and access issues.	• Prepare information and training as part of the induction of new employees and Members	June 2008	HR Director
5c	Further generate and sustain staff awareness of disability and access issues.	• Provide regular information on access and inclusion in Trust News. • Develop and implement a employee recognition program for good practice in access and inclusion	Dec 2006 June 2007	Head of Communications HR Director
5d	Carry out impact assessments on all existing and new Trust policies and procedures that are relevant to disabled people to ensure that they do not disadvantage disabled people.	• Identify and review all policies and procedures that are relevant to disabled people and undertake an impact assessment. • Ensure an impact assessment is carried out on all new policies and procedures that are relevant to disabled people as part of the development process.	June 2008 Feb 2007	Relevant Directors Deputy CEO

	Strategy	Task	Task Timeline	Responsibility
6a	Ensure that current grievance/complaints mechanisms are accessible for people with disabilities.	• Review current mechanisms for making grievances / complaints. Consult with people with disabilities and other expert advice. • Develop other methods of making complaints such as web-based forms. • Promote accessible complaints mechanisms to staff and the public.	June 2007	HR Director
6b	Improve staff knowledge so they can receive complaints from people with a disability.	• Review training needs of staff and roll out training. • Undertake research to identify alternative means of providing grievance feedback (for full implementation by June 2008).	June 2008	HR Director
6c	Ensure that grievance/complaints mechanism processes and outcome satisfaction survey forms are available in formats to meet the needs of people with disabilities.	• Provide grievance mechanism process and patient satisfaction survey forms in alternative formats upon request. • Incorporate good practice in handling complaints from people with disabilities into induction and disability awareness training.	Sept 2007 August 2008	Head of Communications HR Director

	Strategy	Task	Task Timeline	Responsibility
7a	Improve community awareness about consultation processes in place.	• Promote the existence, role and activities of the Trust's Disability Committee. • Disability Committee to meet regularly (as per proposal in action 1) to provide strategic advice and direction. • Ensure Disability Equality Scheme is discussed at the Members' Council	April 2007 April 2007 Dec 2007	Head of Comms Head of Equality and Diversity Deputy CEO
7b	Commit to ongoing monitoring of the DES to ensure implementation and satisfactory outcomes.	• Disability Committee to regularly monitor the implementation and impact of the DES. • Consult people with disabilities in a range of different consultation mediums, eg focus group, interviews, surveys as part of this process • Develop a register of experienced persons to provide comment on access and inclusion issues on request, who may not be members of the Disability Committee.	December 2007	Disability Committee
7c	Improve access for people with disabilities to the established consultative processes of the trust.	• Ensure agendas, minutes and other documents are available on request in alternative formats and are published on the Trust's website. • Investigate options for presenting questions at Trust meetings in alternative formats. • Research feasibility of installing an audio loop at all reception desks.	December 2007 June 2007 June 2008	Head of Communication
7d	Seek a broad range of views on disability and access issues from the local community.	• Include appropriate questions about access and inclusion in general surveys and consultation events. • Disability Committee activity to seek the views of people with disabilities on a wide range of issues.	Dec 07 April 07	Head of Communication Disability Committee

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 23rd November 2006

AGENDA ITEM NO.	3.9/Nov/06
PAPER	Schedule of Meetings
AUTHOR	Fleur Hansen, Foundation Trust Lead
LEAD	Juggy Pandit, Chair
SUMMARY	This paper details the proposed schedule of dates for Members' Council meetings for 2007.
DECISION/ ACTION	The Members' Council is asked to note these dates and suggest any amendments.

SCHEDULE OF MEETINGS

1.0 INTRODUCTION

1.1 It is proposed that the Members' Council meetings be held quarterly commencing in November.

1.2 It is proposed that the meetings be held on the second Thursday after the Board of Directors meeting at 4.30pm. This is consistent with the preferences expressed by the Members' Council.

1.3 It is proposed that all meetings are held in the Hospital Boardroom unless specified.

2.0 SCHEDULE OF MEETINGS

8th February 2007
10th May 2007
9th August 2007
8th November 2007

3.0 DECISION/ACTION REQUIRED

3.1 The Members' Council is asked to note these dates and suggest any amendments.

Fleur Hansen
Foundation Trust Lead
14th November 2006