Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting

Hospital Boardroom
Chair: Prof. Chris Edwards
Date: 8 November 2007
Time: 4:30pm

Agenda

1. GENERAL BUSINESS	**4.30pm**
1.1 Apologies for Absence	**CE**
1.2 Declaration of Interests	**CE**
1.3 Minutes of Previous Meeting held on 20 September 2007 (attached)	**CE**
1.4 Matters Arising (attached)	**CE**
1.5 Chairman's Report (attached)	**CE**
2. ITEMS FOR DISCUSSION/DECISION/APPROVAL	**4:45pm**
2.1 Annual Audit Letter (attached)	**HB**
2.2 Healthcare Commission Standards for Better Health Assurance (attached)	**CM**
2.3 Local Involvement Networks (LINKs) (attached)	**AMC**
2.4 Membership Report (attached)	**JC**
2.5 Draft Minutes from Membership Development and Communications Sub-Committee	**JC**
2.6 Membership Engagement (attached)	**JC**
2.7 Report from National Governors' Forum (attached)	**VA**
2.8 Business Planning (attached)	**LB**
2.9 Infection Control Update (Presentation)	**AMC**
2.10 Proposed Constitutional Change (attached)	**CE**
3. ITEMS FOR INFORMATION	**5:30**
3.1 Finance Report – Q2 (attached)	**LB**
3.2 Performance Report Q2 (attached)	**LB**
4. ANY OTHER BUSINESS	
5. DATE OF THE NEXT MEETING	
14th February 2008	

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 14th February 2008

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

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Date…… **Signed……**

DRAFT
Members' Council Meeting Minutes, 8 November 2007

Present:

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

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

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

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

1. GENERAL BUSINESS

1.1 Apologies for Absence

Apologies for absence were received from:

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

1.2 Declaration of Interests

None

1.3 Minutes of the Previous Meeting Held 20 September 2007

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

1.4 Matters arising

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

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

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

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

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

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

1.5 Chairman's Report

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

CE noted the good turnout at the AGM.

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

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

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

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

2. ITEMS FOR DECISION/APPROVAL

2.1 Business Planning

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

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

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

2.2 Annual Audit Letter

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

2.3 Local Area Involvement Networks (LINks)

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

2.4 Membership Report

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

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

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

2.5 Draft Minutes from Membership Development and Communications Sub-Committee

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

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

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

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

2.6 Membership Engagement

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

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

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

2.7 National Governors Forum

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

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

2.8 Healthcare Commission Standards for Better Health

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

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

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

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

2.9 Infection Control Update

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

2.10 Proposed Constitutional Change

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

THE CONSTITUTIONAL CHANGE WAS AGRED.

3.1 Finance Report – 6 Months to September 07

The Council noted the report.

3.2 Performance Report – 6 Months to September 07

The Council noted the report.

QUESTIONS FROM THE PUBLIC

None

4. ANY OTHER BUSINESS

No other business was raised.

5. DATE OF NEXT MEETING

14 February 2008

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 8th November 2007

AGENDA ITEM NO.	1.3/Nov/07
PAPER	Minutes of the Previous Meeting held 20th September 2007
AUTHOR	Julie Cooper, Foundation Trust Secretary/Head of Corporate Governance
LEAD	Juggy Pandit, Chairman
EXECUTIVE SUMMARY	This paper outlines key issues for the attention of the Members Council.
DECISION/ ACTION	1. To agree the minutes as a correct record. 2. The chairman to sign the minutes.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Date…… **Signed……**

DRAFT
Members' Council Meeting Minutes, 20 September 2007

Present:

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

Council Members:
Juggy Pandit (JP), Chairman
Julie Cooper (JC), Foundation Trust Company Secretary

Frances Taylor (FT), Appointed - Royal Borough of Kensington & Chelsea
Jim Smith (JS), Patient
Jean Hunt (JH), Patient
Catherine Longworth (CL), Westminster PCT
Valerie Arends (VA), Public – Kensington and Chelsea
Lionel Foulkes (LF), Public – Wandsworth 2
Sandra Jowett (SJ), Appointed – Thames Valley University
Maria-Elena Arana (MA), Patient
Vivian Wood (VW), Hammersmith and Fulham PCT
Sue Harris (SH), Staff – Nursing & Midwifery
Andrew Kenworthy (AK), Appointed, Kensington & Chelsea PCT
Jane King (JK), Patient
Michael Henry (MH), Patient
Alison Delamare (AD), Staff – Contracted
Cathy James (CJ), Staff – A&C
Martin Rowell (MR), Patient
Ann-Mills Duggan (AMD), Public – Westminster Area 1
Nathan Billing (NB), Staff-Allied Health Professionals
Chris Birch (CB), Patient

In Attendance:
Heather Lawrence (HL), Chief Executive
Maxine Foster (MFo), Director of Human Resources
Amanda Pritchard (AP), Deputy Chief Executive
Charles Wilson (CW), Non-Executive Director
Marilyn Frampton (MFr), Vice-Chairman
Amit Khutti (AKh), Director of Strategy and Service Performance
Lorraine Bewes, Director of Finance
Hannah Coffey, Director of Operations
Four members of the Public

1. GENERAL BUSINESS

1.1 Apologies for Absence

Apologies for absence were received from:
Brian Gazzard (BG), Staff – Medical & Dental
Duncan Macrae, Appointed - Royal Brompton & Harefield NHS Trust
Christine Blewett (CB), Public – Hammersmith & Fulham 2
Nicky Browne (NH), Royal Marsden NHS Foundation Trust
Mervyn Maze (MM), Imperial College

1.2 Declaration of Interests

None

1.3 Minutes of the Previous Meeting Held 24 July 2007

The minutes were approved with the following amendments:

Item 3.1 LINKs should read Local Involvement Networks

1.4 Matters arising

Matters Arising (1.4/Jul/07)
Open Trust board minutes now posted on the Trust website.

Patientline (1.4/Jul/07)
HL said that since the last discussion, Patientline has informed her that they will not raise prices for incoming calls. JP noted that calls are still expensive in general. HL said that she is happy to take this discussion further if the Members' Council would like her to do so.

Action: HL to bring brief paper on call charges and situation with Patientline to next Members' Council meeting **HL**

Constitutional Changes (2.2/Sept/07)
JP reported that the changes had been submitted to Monitor. He said that they had accepted all of the changes except the proposal to allow named alternates. JP explained that Monitor did not consider it appropriate for appointed governors to have a nominated alternate, able to exercise the same rights as the appointed governor at board of governor meetings. They felt that being able to pass the rights and obligations of a governor between two people did not suggest that the appointed individuals exercise proper responsibility in respect of the trust. Further, Monitor felt using the general principles of company law as an appropriate comparator; directors are named individuals with statutory responsibilities towards the company. To this end, they declined to accept this amendment.

Annual Members Meeting (2.2/Sept/07)
Andrew Kenworthy will be presenting the PCTs perspective at the Annual Members Meeting

Membership Development Strategy (2.4/Sept/07)
JC reported that no one had requested any leaflets. She reiterated the important role that the Members' Council plays in increasing our membership and she asked how she could assist Council Members with this challenge. This was discussed further under agenda item 2.5.

Patient and Public Involvement in Research (2.8/Sept/07)
Derek Bell and Julie Reed attended the Membership Development and Communication Sub Committee and presented their proposal for involving patients in research. VA asked for specific examples of the types of research taking place. She mentioned the work at St. Georges and she asked if there might be duplication. HL said many organisations are working on HIV related research and there was no duplication. **HL/DB**

Action: clarify types of research taking place.

1.5 Chairman's Report

JP presented the report. He said that the Non Executive Director (NED) appointment would be covered under agenda item 2.1. He invited AK to talk to the London Health strategy. AK said that this is a really important process to look at the best use of services and if we are truly putting services to their best use and maximising clinical outcome. He mentioned the Darzi review and said that the document Healthcare for London: A Framework for Action is a public document and stressed that all PCTs and Acute Trusts will be formally consulted. He said that the point of the exercise was to get wider reviews and he stressed that it was important that Members share their views during the public consultation. He said of Lord Darzi's proposals are adopted it will lead to significant changes in the way health services are run in London and that it needs to be balanced with individual and local views in order to get it right. He said this is a huge opportunity for the Members' Council to shape the future direction of healthcare. He said the consultation will be formally launched in November and it will close in February. All of the PCTs have joined together and formed one group to manage the consultation process. CL said that there will most likely be further local consultation once the formal consultation concludes in February.

JP said that we have an amber rating for MRSA. He said this does not mean that we are poor, but rather that we performed well last year. He said that the Healthcare Commission carried out an unannounced visit on 15 August to assess the Trust's compliance with The Health Act 2006: Code of practice for the prevention and control of healthcare associated infections. He said a final report with a rating will be published shortly, but that initial verbal feedback by the inspectors was that ward-based staff 'get the message' about the control of infection but there is room for improvement among staff moving between wards. HL said that other specialist trusts without A & E have less of a problem, as much of our MRSA is community – acquired. She said that we have started with a low target and that a lot of action is being taken to address it. AK said that he was frustrated with this issue as it only looks at hospitals which are really the end point. CL asked if patients are checked on arrival. HL said that we test for all elective surgery but that it is the emergencies that cause the problem. FT raised the issue that the 'caution Hot Water' signs might be putting people off washing their hands. CL asked if PCTs have started the process of liaising with nursing homes over MRSA. AK said that no action had been taken centrally. LF asked what percentage of those bringing MRSA in from the community come from nursing homes. CB noted that only 8 people attended the infection control seminar.

JP announced the opening of the Acute Medical Unit. JP said that there are now 9 vacancies on the Members' Council and that election will be held over the next two and a half months to fill the seats. He said a specific overview of each seat could be sought from Julie.

2. ITEMS FOR DECISION/APPROVAL

2.1 Appointment and Approval of Non Executive Directors (NEDs)

JP presented the report and said that it has been an historical year with some many appointments. JP said that the Nominations Committee of the Members' Council interviewed four candidates for the NED vacancy and that Prof. Edwards joined the committee for the interviews. He said that the interviewed candidates had been short-listed from a long list of 12 candidates who had been interviewed by Saxton Bampfylde Hever. Those 12 candidates had come from the original 33 people who were identified by Saxton Bampfylde Hever or responded to the advertising campaign.

JP announced that following the interviews, the Nominations Committee recommendation to the Members' Council is for the appointment of Mr Colin Glass for a 3-year term starting on 1 November. JP went through Colin's CV including his prior experience and time commitments. He noted particularly his customer service focus and retail background, which we currently lack on the board. He also pointed out his commitment to social service as demonstrated by his work in Asia. VA commented that she felt he was a remarkable man with his diversity of work between PC World and his work with street children.

JP said the second matter to raise was that of the recommendation from the Nominations Committee to reappoint both Charles Wilson and Andrew Havery. He outlined the appraisal process and informed the Council that following discussions with the Nominations Committee they were recommending the reappointment of Charles Wilson for a 2-year term and Andrew Havery for a three-year term, which would both re-commence on 1 November 2007. He added that the committee felt these reappointments were important for continuity of the Board. He noted that their external time commitments have not changed.

Following a briefing from the chairman, the Nominations Committee recommended to the Members' Council that Charles Wilson and Andrew Havery be reappointed as NEDS for a 2-year and 3-year terms respectively.

THE MEMBERS' COUNCIL APPROVED THE APPOINTMENT OF COLIN GLASS AS NED AND THE REAPPOINTMENTS OF CHARLES WILSON AND ANDREW HAVERY.

2.2 Standing Orders

JP said that the changes in the standing orders go in parallel with the changes made to the constitution. He said the main changes are with regards to vacancies, terms of office and elections. JP asked for approval of the new standing orders.

THE STANDING ORDERS WERE APPROVED.

2.3 Annual Member's Meeting

JP said that the Annual Members' Meeting would be held this evening at 5:30 in the hospital dining room. He said that the Martin Rowell would be giving the formal presentation to the membership, but that he hoped all Council Members would make themselves available to speak to members about the work of the Council. He said that a membership table would be setup in the atrium and that Members' Council sashes had been made up to help members identify Council Members. CL asked about holding the Annual Members' Meeting in other venues. JP said that it had been discussed and it was agreed to hold it in the hospital.

2.4 Membership Report

JP asked JC to report on the latest membership figures. JC reported that the overall membership currently stood at 13,139, with public members at 6,607, patient members at 6,114 and staff at 418. JC said the overall goal was to raise the membership by 1000 and she gave the exact figure for each constituency. She stressed that membership recruitment was the responsibility of individual members and she asked how she could help them fulfil this role.

Action: JC to ensure members have leaflets for distribution within their constituencies to promote membership. **JC**

2.5 Draft Minutes from Membership Development and Communications Sub-Committee

JC presented the draft minutes from the last Sub-Committee meeting held on 4 September. She explained that we have now taken the objectives from the Membership Development and Communications Strategy and married them with our ongoing actions to increase membership. She said that the focus at the moment is on membership recruitment as we are required by Monitor to maintain and increase our overall membership as well as ensure its diversity. She said that the committee had worked on the presentation for the Annual Members' Meeting and that we thought it was reflective of our work to date. JC said that we will now be mailing a letter to everyone in the trust who has been here over 12 months and going forward we will be regularly sending out a letter from the chairman to each member of staff on their twelfth month in the trust to invite them to join the trust.

JC said that the committee was also focussed on how to encourage active membership. FT suggested holding member surgeries. JP said he felt this was a good idea but that we needed an appropriate place to hold them. FT suggested that we might also ensure a stock of leaflets at the local libraries. JC also reported that we are looking to have volunteers help us with recruitment. AMD said that she feels like we need a conduit as it is difficult to reach her constituents. JC said that we are also going to be reintroducing NHS discounts which should offer an incentive for people to join. MR said that we need to remind people of the benefits of being a member and why they should join. He gave the example of involvement in research. LF said we need to be more proactive. Council Members agreed to take leaflets and distribute them in local GP surgeries.

Action: Explore idea of surgeries in outpatients and A&E **JC**
Action: Put leaflets in information exchange at St. Stephens **JC**
Action: Council Members to distribute leaflets in GP surgeries **ALL**
Action: Bring paper back with ideas on how to increase membership **JC/ALL**

THE MINUTES WERE APPROVED.

2.6 Members' Council Agenda – Future Items

JP said as we move into our next year he would invite Council Members to think about matters they would like to see as future agenda items and he suggested that they be emailed to Julie.

Action: Email suggestions for future agenda items to JC

2.7 Members' Council – Draft Dates for Next Year

JP said the last meeting for this year will take place on 8 November. He asked that Council Members note the dates of the meeting for next year and he said the October meeting will most likely take place in the 3rd or 4th seek in September to accommodate the Annual Members Meeting.

3.1 Finance Report – Quarter to June 07

LB presented her report. The key message is that we are doing well, which is largely driven by high income. CL asked LB to say a bit more about risk. LB said as a general principle if finance is aware of a risk then we adopt the worst case scenario. She said the main risk is whether we can deliver the 18 week activity plan within our budgeted resources. LB said another risk is HIV drug spend. She said the nature of the risk is that the projection is based on current projected growth, but by and large the way we are funded means it rises and falls. She said another risk is pathology. We purchase £8M worth of services from Hammersmith Hospital, but we do not have a robust contract. We are now looking to formalise the contract with proper performance evaluation. She said private patients are highlighted because income is below plan. LF asked if we are affected by overseas patients and tourists using our services without payment. LB said yes we are affected as are all other trusts. LB said the cost varies year on year, and the board is paying particular attention to this matter. She said it is a problem which is not easily resolved. HL said this is a problem in that we do not always recover the money, but sometimes we have to do it as we are an acute hospital. JP assured the Council that the board was vigilant on this matter. CL asked where the bottlenecks were with delivering on 18 weeks. HL said hand surgery and one or two others. AK said 18 week target is a must for both PCTs and Acute Trusts and it is a great piece of work.

3.2 Performance Report – Quarter to June 07

LB said that HL had already emphasised some of the key messages. She asked the Council to look at page 5 at the dashboard. JP explained that anything in green was okay and amber areas needed attention. LB said we did notify Monitor that we will likely not meet the MRSA target. LB said that in the other Healthcare Commission targets we have done well, but that we have tailored off in data quality. She said the other important target is *C.Difficile* and at the moment we are not meeting the target. MA asked about data quality and what it entailed. LB said that it is used to measure how well we record ethnicity. LB said that we are likely to achieve this target. JS asked why we struggling with MRSA. JP explained that we had started with a higher standard and so it is now harder to achieve the target set for us. HL said we know from the Healthcare Commission inspection that our teams know what to do. CB said it is impressive report but full of codes and jargon.

AK said well done in terms of GUM and cancer targets as there is there is clearly significant improvement in these areas.

Action: Attach glossary of terms to future papers

QUESTIONS FROM THE PUBLIC

None

5. ANY OTHER BUSINESS

No other business was raised.

6. DATE OF NEXT MEETING

8 November 2007

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 8th November 2007

AGENDA ITEM NO.	1.4/Nov/07
PAPER	Matters Arising
AUTHOR	Julie Cooper, Foundation Trust Secretary
LEAD	Chris Edwards, Chairman
EXECUTIVE SUMMARY	This paper lists matters arising from previous meeting(s) and the action taken/to be taken.
DECISION/ ACTION	The Members' Council is asked to note the matters arising and update where appropriate.

Matters Arising from Previous Meetings

Reference	Item	Action
1.4/Sept/07	PATIENTLINE HL to bring brief paper on call charges and situation with Patientline to next Members' Council meeting	JC
1.4/Sept/07	PATIENT AND PUBLIC INVOLVEMENT IN RESEARCH Clarify types of research taking place at C & W	HL
2.4/Sept/07	MEMBERSHIP REPORT Ensure members have leaflets for distribution within their constituencies to promote membership.	JC
2.3/Sept/07	MINUTES FROM MEMBERSHIP DEVELOPMENT AN COMMUNICATIONS SUB COMMITTEE 1. Explore idea of surgeries in outpatients and A&E 2. Put leaflets in information exchange at St. Stephens 3. Council Members to distribute leaflets in GP surgeries **4.** Bring paper back with ideas on how to increase membership	 JC JC ALL JC/ALL
2.6/Sept/07	MEMBERS' COUNCIL FUTURE AGENDA E-mail suggestions for future agenda items to JC	ALL
3.2/Sept/07	PERFORMANCE REPORT Attach glossary of terms to future papers	JC

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 8th November 2007

AGENDA ITEM NO.	1.5/Nov/07
PAPER	Chairman's Report
AUTHOR	Chris Edwards, Chairman
LEAD	Chris Edwards, Chairman
SUMMARY	This report outlines key issues for the attention of the Members' Council.
DECISION/ ACTION	The Council is asked to note the report.

Chairman's Report

1.0 HEALTHCARE COMMISSION ANNUAL RATING

I am delighted to say that the Healthcare Commission, the independent health watchdog in England which has published ratings for every NHS trust, gave Chelsea and Westminster a score of Excellent for the quality of our services and Excellent for our use of financial resources. A letter announcing this news was also sent to all Council Members by post.

The Healthcare Commission's rating demonstrates the tangible improvements in the quality of care for patients that our staff have delivered over the last 12 months – in 2006 we scored Good for quality of services and Fair for use of resources.

Only 19 NHS trusts in England scored Excellent for both quality of services and use of resources and so our performance places us in the top 5% of trusts nationally. We are in the top 4% of NHS trusts in London where only 3 NHS trusts achieved a double score of Excellent.

Our performance enhances Chelsea and Westminster's excellent reputation as a leading NHS hospital and I want to congratulate all staff on a job well done.

2.0 ANNUAL MEMBERS' MEETING FEEDBACK

More than 200 people attended the Trust's Annual Members' Meeting in September to hear about the last year in the life of Chelsea and Westminster Hospital. This attendance demonstrates the high level of interest in the hospital among our patients and the local public.

3.0 LONDON HEALTH STRATEGIES

Chief Executive Heather Lawrence has held four briefings for Trust staff about major reviews of the NHS in London – all staff attending the briefings have been given a Powerpoint presentation and printed materials to ensure an effective communication cascade in all directorates and key areas.

4.0 INFECTION CONTROL - HEALTHCARE COMMISSION VISIT

The Healthcare Commission carried out an unannounced visit on 15 August to assess the Trust's compliance with the Health Act Hygiene Code – they visited David Erskine and Lord Wigram wards and the Acute Medical Unit.
A final report with a rating will be published shortly. Initial verbal feedback by the inspectors was that ward-based staff 'get the message' about the control of infection but there is room for improvement among staff moving between wards.

5.0 OPENING OF ACUTE MEDICAL UNIT (AMU)

A brand new Acute Medical Unit (AMU) opened at Chelsea and Westminster on Monday 6 August. The AMU, which is located on the site of the old Frances Burdett Ward, includes 21 inpatient beds and a five-trolley assessment area to provide specialist care for adult patients with a wide range of medical conditions. It is staffed by a dedicated team of nurses, doctors, therapists, pharmacists and other healthcare professionals so that patients can access the most appropriate treatment as quickly as possible – Charge Nurse Steve Burwell is the Ward Manager.

6.0 CHELSEA AND WESTMINSTER DUATHELON

Chelsea and Westminster Health Charity is sponsoring the world's largest duathlon – a challenging mix of running and cycling – to help raise money for the hospital.

The Chelsea and Westminster Health Charity London Duathlon will take place in Richmond Park on Sunday 14 September 2008 and staff, volunteers, Members and everyone connected with the hospital is being urged to get involved.

Visit www.londonduathlon.com from Tuesday 6 November to register for the event.

7.0 PAEDIATRICS

The Primary Care Trusts in North West London are taking forward a review looking to concentrate specialist paediatric services in our sector due to worries over a number of years that a fragmented service is damaging for patient care. The focus of the review is on co-locating paediatric and neonatal surgery, most of which is provided at Chelsea & Westminster, paediatric intensive care which is provided at St. Mary's Hospital, and neonatal intensive care which is provided at both hospitals. The Royal Brompton Hospital offers the only essential paediatric intensive care, but is not a focus of the review.

The benefit criteria for reviewing proposals which have yet to be weighted are as follows:

Neonatal and Specialist Paediatric Surgery Commissioning in NW London	
a. Strategic Fit	Provides a service configuration which is compatible with local and national strategic priorities
b. Quality of Care	Provides a high quality service in keeping with the national guidance, standards and frameworks
c. Supports Workforce Planning	Provide a workforce and staffing rotas that are compatible with a high quality safe service
d. Patient experience	Improves the patient and parent experience
e. Effective use of resources	Demonstrates the potential to best use the surgical and critical care resources with streamlined care
f. Research	Creates an environment where research and development can be conducted for the benefit of the local child population
g. Implementability and sustainability	The proposal is able to be implemented in the timelines identified

Paediatric surgery at Chelsea & Westminster is a key part of our comprehensive paediatrics service. As well as being the local hub for paediatric surgery and having a large neonatal intensive care unit (NICU), we also have 24/7 paediatric anaesthesia, the sector's largest 24/7 paediatric A&E department and a number of specialist services including: gastroenterology, endocrinology, neurology, respiratory, dermatology, craniofacial, plastics and burns, ENT, dental, ophthalmology and orthopaedics.

Our paediatric surgery patients come from a wide catchment area – 70% from North West London, 17% from the rest of London and 13% from outside London. Within North West London we are the largest provider of paediatric surgery for every PCT except Westminster PCT, including over 70% of the activity for Ealing, Hounslow and Hammersmith & Fulham PCTs. This shows that patients are willing to travel to access our specialist services.

Annual Audit Letter 2006-07

To the Members' Council

Chelsea and Westminster Hospital NHS Foundation Trust

The Purpose of this Letter

1. The purpose of this Annual Audit Letter (letter) is to summarise the key issues arising from the work that we have carried out during the year. This letter is addressed to the Members' Council of the Trust and is intended to communicate the significant issues we have identified in an accessible style to the Council, as well as the wider Member population of the Trust. We have previously discussed our formal reporting to 'those charged with governance' as required by International Standards on Auditing (UK & Ireland) with both the Audit Committee and the Board of Directors.

Responsibilities of the auditor and the Trust

2. We have been appointed as the Trust's independent external auditors by the Members' Council of the Trust.

3. As the Trust's external auditors, we have a broad remit covering financial and governance matters. We target our work on areas which involve significant amounts of public money and on the basis of our assessment of the key risks of the Trust achieving its objectives. It is the responsibility of the Trust to ensure that proper arrangements are in place for the conduct of its business and that public money is safeguarded and properly accounted for. We have considered how the Trust is fulfilling these responsibilities.

The scope of our work

4. Our main responsibility as your appointed auditor is to plan and carry out an audit. As part of this responsibility we are required to review and report on:

    - the Trust's accounts; and
    - to report by exception on whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

5. This letter summarises the significant issues arising from both these areas of work and highlights the key recommendations that we consider should be addressed by the Trust.

Key issues arising from the audit of the accounts

6. We have planned and performed our audit on the basis of our assessment of risk in respect of the above audit and reporting responsibilities. Our plan was tailored to local circumstances and was based on our assessment of financial risks and significant operational and performance-related risks, relevant under the Code. We have examined and assessed Chelsea & Westminster Hospital NHS Foundation Trust's processes so

that we could place as much reliance as possible on the Trust's own processes, in determining the scope of audit work to be carried out.

7. We were able to issue an unqualified (or 'clean') opinion on the Trust's accounts for the six month period to 31 March 2007 (the first period in which the Trust operated as a Foundation Trust) by 11 June 2007, the deadline set by Monitor, the Foundation Trust regulator. Our opinion confirms that the accounts give a true and fair view of the Trust's financial affairs and of the income and expenditure recorded by the Trust during the year. At this time, we also issued our unqualified opinion on the accounts for the 6 month period to 30 September 2006 for the predecessor NHS Trust.

8. As noted above, before we gave our opinion on the accounts, we reported to the Trust's audit committee on significant matters arising from the audit, in their capacity as 'those charged with governance'. A detailed report was issued in June 2007 and only the key issues are summarised here. No significant audit adjustments were noted.

Monitor's report

9. We mentioned in our interim report to the Audit Committee that in Monitor's report for the 9 months to December 2006, the Trust was highlighted as one of the eight Foundation Trusts that most successfully combined financial and service performance in quarter three of 2006/07. We understand that relationships with Monitor continue to be strong.

Financial Standing

10. NHS Foundation Trusts are required to comply with the Prudential Borrowing Code. As such, they are subject to monitoring of various covenants (primarily in the form of financial ratios) as part of the Prudential Borrowing Code which needs to be reported within the financial statements. We have reviewed management's calculations of these ratios and have concluded that (a) they are calculated in line with the definitions set out within the guidelines set forth by Monitor, based on the Prudential Borrowing Code, and (b) the Trust has not breached any of these covenants.

Key issues arising from the review of the Trust's use of resources

11. We were required to report by exception on whether we were satisfied that the Trust had put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources (commonly referred to as 'value for money').

12. Our value for money review did not raise any issues, and there were no significant points to note.

Key recommendations

13. During the year we made a number of recommendations to the Trust. None of these were these were high priority.

Analysis of Audit Fees

14. Our audit fees paid by the Trust were consistent with the level agreed and set out in our audit plan.

2007/2008

15. Given our knowledge of financial pressures across the NHS in London, the Trust needs to continue to focus on strict performance and financial management. We will continue to monitor this in the coming year.

16. We noted that during the March 2007 budget the Chancellor announced his intention for the whole of Government Accounts to be produced in accordance with International Financial Reporting Standards (IFRS) for the year ended 31 March 2009. There is an expectation that NHS Foundation Trusts will be required to report under IFRS for the year ended 31 March 2009. There are expected to be a few changes in the reporting requirements and accounting methods due to this change.

    In order to prepare for the transition to IFRS, the comparatives for 2009, which is the year ended 31 March 2008, will also need to be restated in accordance with IFRS. It is expected that for the financial year ending 31 March 2008, the figures will be prepared under UK GAAP and finalised in summer 2008. These figures will need to be re-stated under IFRS and finalised in the autumn 2008. The financial statements for the year ending 31 March 2009 will be prepared under IFRS and finalised in the summer 2009.

    Our experience in the private sector suggests that transitioning to IFRS can be a significant challenge. We will continue our discussions with the Trust on this topic over the coming year, in order for us to review the planning for and progress towards the implementation of IFRS. We will be able to share our knowledge of best practice and experience from assisting private sector entities transition to IFRS.

Independence and objectivity

17. In our professional judgement the policies and safeguards we have in place ensure that we are independent within the meaning of all regulatory and professional requirements and that the objectivity of the audit partner and audit staff is not impaired.

Closing remarks

18. The letter is to be presented to the meeting of the Members' Council, following discussion with the Director of Finance. A copy has also been provided to all Board Members.

19. We would like to take this opportunity to express our appreciation for the assistance and co-operation provided by management during the course of the audit. Our aim is to deliver a high standard of audit which makes a positive and practical contribution which supports the Trust's own agenda. We recognise the value of the co-operation and support of the Trust.

Deloitte & Touche LLP

September 2007

We view this report as *part of our service to you for use* as *Members of Chelsea and Westminster Hospital NHS Foundation Trust for governance purposes and it is to you alone that we owe* a *responsibility for its contents.*

The matters raised in this report are only those that came to our attention during our audit and are not necessarily a *comprehensive statement of all weaknesses that exist or of all improvements that might be made. You should assess recommendations for improvements for their full implications before they are implemented.*

It is the responsibility of audited bodies to maintain adequate and effective financial systems and to arrange for a *system of internal controls over the financial systems. Auditors should evaluate significant financial systems and the associated internal controls and, in doing so, be alert to the possibility of fraud and irregularities. Our findings are based upon an assessment of the design of controls at the time of review. We did not necessarily review the operation of controls throughout the financial year.*

For your convenience, this document has been made available to you in electronic format. Multiple copies and versions of this document may therefore exist in different media - in the case of any discrepancy the final signed hard copy should be regarded as *definitive. Earlier versions are drafts for discussion and review purposes only.*

Members' Council Meeting, 8th November 2007

AGENDA ITEM NO.	2.1/Nov/07
PAPER	Business Planning 2008/09
AUTHOR	Amit Khutti, Director of Strategy and Service Performance
LEAD	Lorraine Bewes, Director of Finance and Information
SUMMARY	The membership and the Members' Council play a vital role in providing a community perspective to service development. The annual service planning process sets out a clear and shared vision amongst staff, members and external stakeholders of how the Trust and individual directorates will develop over the next 12 months. This paper sets out a robust process for involving the Members' Council and builds on the strengths of last year's approach to annual planning which involved significant consultation with staff and which incorporated feedback from the Members Council.
DECISION/ ACTION	The Council is asked to review and agree the proposed approach.

Approach to Annual Planning for 2008/09

Purpose of annual planning
The annual service planning process and resulting products should fulfil several functions:

1. Set out a clear and shared vision amongst staff, Members and external stakeholders of how the Trust and individual directorates will develop over the next 12 months;
2. Set out how the Trust will deliver both excellent service quality and excellent use of resources by identifying key corporate aims and objectives, targets, planned activity and new developments and how resources will be deployed to achieve these;
3. Ensure bottom-up directorate plans are aligned with corporate aims, values, objectives and targets;
4. Capture both top-down and bottom-up plans in an overall annual plan which will serve as a basis for ongoing in-year reviews between the Executive Team and individual directorates;
5. Allows the Executive Team to provide assurance to the Board, to Monitor (the regulator of Foundation Trusts) and to the Membership Council on planning for 2008/09 and on performance against plan.

Trust approach to annual planning

We intend to build on the strengths of last year's approach to annual planning which involved significant consultation with staff and which incorporated feedback from the Members Council.

Although the details of our approach are being agreed, the broad outline will be as follows:

- The Board and senior managers will discuss the key strategic issues facing the Trust and agree key corporate aims and objectives;
- Closer engagement with Kensington & Chelsea PCT as our Lead Commissioner to ensure we have a shared understanding of the health needs and demand for acute services of our patient population;
- Directorates will develop their own plans through widespread consultation with staff. Directorate plans must take forward corporate aims and objectives, as well as developing local initiatives in alignment with the corporate aims;
- Financial and activity planning will start earlier than last year, with key assumptions and approach circulated and agreed with the directorates;
- Directorate plans will be challenged and agreed through a series of bilateral meetings with the Trust Executive team.

How would the Members Council like to get involved in annual planning for 2008/09?

We would like to understand how the Council would like to be involved in this year's annual planning cycle, and have outlined different options below.

According to the Trust constitution, one of the Members Council's roles and responsibilities is to:

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

Last year the Members Council was invited to attend workshops led by the Deputy Chief Executive and the Director of Finance and Information, to comment in particular on the Trust's draft Corporate Objectives. Valuable feedback was received from these workshops and the Objectives were refined accordingly (last year's final Corporate Objectives are attached in Appendix 1 for information).

In terms of the Members Council's input this year, we are suggesting any or all of the options below could be followed:

1. **Vision and values:** We are planning on reviewing the Trust's vision and values. The Members Council could provide valuable input into this review, for instance through a one-off workshop or by setting up a short-lived working group;
2. **Feedback on Corporate objectives:** Building on last year's approach, asking the Members Council to provide feedback on the Trust's draft Corporate Objectives once these have been discussed by the Trust's senior managers. To deepen the engagement, the Members Council, particularly but not exclusively staff representatives, could also provide valuable advice on how the Trust Executive can make these objectives 'live' within the organisation;
3. **Allocating discretionary spend:** As a Foundation Trust it is important that we create a surplus to reinvest in maintaining and upgrading our services. However, if we deliver our financial plan for this year, we will generate a reasonable surplus and are likely to be in the position of having some discretionary one-off funding available. If the Members Council thought it appropriate, they could provide direction as to what initiative(s) this one-off funding could support. Through delivering the financial plan, this funding is likely to be up to £100,000 at year-end.
4. **Involving the wider Membership:** The Council may also want to provide a means of involving the wider Membership in annual planning. One option would be for a working group to develop survey questions about development priorities for the Trust which we could mail out to the Membership.

We would appreciate the Members Council's views on whether any of the options outlined above, or indeed other options, are suitable.

Amit Khutti
Director of Strategy and Service Performance
29th October 2007

Appendix 1

CORPORATE AIMS AND VALUES 2007/08

1. Patient Experience: To improve all aspects of the patients' experience, to continue to make the patient the centre of everything we do through a focus on consistently excellent customer care and consequently be the provider of choice.

2. Clinical Governance and Safety: To maintain quality and efficiency and continuously improve patient outcomes and assure patient safety.

3. Service Line Reporting: To develop an understanding of service line profitability to support strategic service planning, investment and performance improvement and promote good business practice..

4. Teaching: To provide excellent teaching, learning and development opportunities for all staff.

5. Specialist Services: To maintain and develop our specialist services.

6. Strategic Partnerships: To develop effective partnerships with all stakeholders, including the Members Council.

7. Our Workforce: To ensure we have a highly skilled, motivated, diverse, productive and customer focused workforce.

8. Modern Infrastructure: To ensure clinical care is supported and enabled by effective modern support services.

9. Innovation: To be innovative with our clinical services and business models, using the new Foundation Trust freedoms.

10. Integrated Governance: To further develop the Trust's framework for integrated governance.

Members' Council Meeting, 8th November 2007

AGENDA ITEM NO.	2.8/Nov/07
PAPER	Healthcare Commission Standards for Better Health Assurance
AUTHOR	Catherine Mooney, Director of Governance and Corporate Affairs
LEAD	Catherine Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	This paper provides a brief overview of the Healthcare Commission Standards for Better Health and suggests a process by which the Members' Council can be involved in the self assessment process of whether or not the trust is compliant against the standards.
DECISION/ ACTION	The Members' Council is asked to agree on a way forward for their involvement in the declaration on core standards.

Standards for Better Health 2007/2008

1. Introduction

The government published Standards for Better Health in July 2004, which set out 24 core standards. These standards describe a minimum level of service which all organisations are expected to meet or aspire to across the NHS in England. They provide a framework for continuous improvement in the overall quality of care people receive.

The Standards for Better Health are structured around seven domains. These are:

Safety
Clinical and Cost Effectiveness
Governance
Patient Focus
Accessible and Responsive Care
Care Environment and Amenities
Public Health

These domains contain both core and developmental standards. Organisations are expected to self assess against the core standards and provide a declaration to the Healthcare Commission. Each standard has one or more elements. See appendix 1 for a list of the core standards. As part of the declaration process the Trust is required to invite stakeholders, including the Members' council, to comment on its declaration.

2. Assurance report for 2006/07

The assurance report consisted of the standards and elements and a description for each element of the evidence to support the declaration of compliance and the information available to support the evidence.

3. Process for 2006/07

The Audit Committee agreed the process for assurance of the core standards. Each director was allocated a standard and served as lead director for all the elements within the standard. The lead director reviewed the evidence listed and information available to support the evidence and updated it. Each standard had a peer review director who also reviewed the nominated element and evidence. The lead director also assessed whether the trust was compliant with that standard and whether there were any risks to maintaining compliance. Those that had potential risks were discussed in more detail at the Audit Committee to ensure compliance. The Board confirmed the Trust declaration of 'compliant' against each core standard and approved the statement on the Code of Practice on Healthcare Associated Infections for 2006/07. The final draft was submitted to the Overview and Scrutiny Committee (OSC) and the Patient and Public Involvement (PPI) Forum. Their comments were published with the Trust's declaration.

4. Plans for 07/08

The Healthcare Commission have agreed to rationalise and reduce the number of criteria for assessment of compliance with the standards. The revised criteria are not available yet. There will be no separate declaration on progress against the developmental standards.

5. Role of the Members Council

Trusts can invite their Members Council to comment on performance in relation to core standards. This is beneficial as it can provide the views and experiences of people in the local community. There are numerous ways in which the Council can get involved. There is a section in the declaration that allows the comments of the Members' Council to be submitted.

6. Options for involvement

Outlined below are a two options on how the Members' Council might get involved in preparing the Healthcare Commission declaration of assurance. The Council may choose to follow one or both of the options outlined below depending on the level of involvement Council Members would like to have.

Option 1
The Members' Council identifies the standards and/or areas for which they would like to contribute referring to appendix 1. Council Members could then act as 'lead Councillors' for specific standards and/or areas and assist in gathering evidence for assurance.

Option 2
The Members' Council identifies the standards and/or areas for which they would like to contribute referring to appendix 1. One or more half day sessions will then be organised in January with lead directors present, for Council Members to review the assurance statements, identify further activity or evidence, identify areas for which further evidence might be needed and check reference availability. Tables could be set up for each relevant domain so that Council Members could get involved in as many areas as they felt comfortable doing. A report would then be submitted to the Members' Council in February and then to the Board to allow the Board to take the comments into account in the final declaration.

7. Facilitating involvement

Tips from the Healthcare Commission to help ensure Council Members comments make a difference are noted below:

- Think about what matters most to you and the people in your community – what are the most important points you want to get across?
- Think about examples of good practice as well as problems and areas for improvement
- Familiarise yourself with the 24 core standards and guidance relating to them. Aim to match the standards with the points you want to make
- Try to find facts and examples to back up your comments. These may include notes of a meeting or visit to a trust, the results of a local survey, or personal stories from individuals with supporting dates and documents

8. Action

The Members' Council is asked to agree on a way forward for their involvement in the declaration on core standards considering the options outlined above.

Catherine Mooney
October 2007

Appendix 1

Standards for Better Health 2006/07

Standard	
Ref	**DOMAIN – SAFETY**
C1	Healthcare organisations protect patients through systems that: a) identify and learn from all patient safety incidents and other reportable incidents and make improvements in practice based on local and national experience and information derived from the analysis of incidents b) ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required timescales
C2	Healthcare organisations protect children by following national child protection guidelines within their own activities and in their dealings with other organisations a) The healthcare organisation has defined and implemented effective processes for identifying, reporting and taking action on child protection issues, in accordance with the Protection Of Children Act 1999, the Children Act 2004, Working together to safeguard children (HM Government, 2006) and Safeguarding children in whom illness is induced or fabricated by carers with parenting responsibilities (Department of Health July 2001). b) The healthcare organisation works with all relevant partners and communities to protect children in accordance with Working together to safeguard children (HM Government, 2006). c) Criminal Records Bureau (CRB) checks are conducted for all staff and students with access to patients and relatives in the normal course of their duties. In carrying out CRB checks the healthcare organisation should be meeting the requirements of CRB disclosures in the NHS (NHS Employers 2004).
C3	Healthcare organisations protect patients by following NICE interventional procedure guidance
C4	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that: a) the risk of healthcare acquired infection to patients is reduced with particular emphasis on high standards of hygiene and cleanliness, achieving year on year reductions in MRSA b) all risks associated with the acquisition and use of medical devices are minimised c) all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed d) medicines are handled safely and securely e) the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment
	DOMAIN – CLINICAL AND COST EFFECTIVENESS
C5	Healthcare organisations ensure that a) they conform to NICE technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care b) clinical care and treatment are carried out under supervision and leadership c) clinicians continuously update skills and techniques relevant to their clinical work d) clinicians participate in regular clinical audit and reviews of clinical services
C6	Healthcare organisations cooperate with each other and social care organisations to ensure that patients individual needs are properly managed and met

Standard	
	DOMAIN- GOVERNANCE
C7	Healthcare organisations a) apply the principles of sound clinical and corporate governance b) actively support all employees to promote openness, honesty, probity, accountability and the economic, efficient and effective use of resources c) undertake systematic risk assessment and risk management d) ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources e) challenges discrimination, promote equality and respect human rights f) meet exists performance requirements
C8	Healthcare organisations support their staff through a) The healthcare organisation has arrangements in place to ensure that staff know how to raise concerns, and are supported in so doing, in accordance with The Public Disclosure Act 1998: Whistle blowing in the NHS (HSC 1999/198). b) The healthcare organisation supports and involves staff in organisational and personal development programmes as defined by the relevant areas of the Improving Working Lives standard at Practice Plus level. c) Staff from minority groups have opportunities for personal development in accordance with Leadership and Race Equality in the NHS Action Plan (Department of Health 2004).
C9	Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required
C10	Healthcare organisations a) undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies b) require that all employed professionals abide by relevant published codes of professional practice
C11	Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare a) are appropriately recruited, trained and qualified for the work they undertake b) participate in mandatory training c) participate in further professional and occupational development commensurate with their work throughout their working lives
C12	Healthcare organisations which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied
	DOMAIN – PATIENT FOCUS
C13	Healthcare organisations have systems in place to ensure that a) staff treat patients, their relatives and carers with dignity and respect b) appropriate consent is obtained when required for all contacts with patients and for the use of any confidential patient information c) staff treat patient information confidentially, except where authorised by legislation to the contrary
C14	Healthcare organisations have systems in place to ensure that patients, their relatives and carers a) have suitable and accessible information about, and clear access to procedures to

Standard	
	register formal complaints and feedback on the quality of services b) are not discriminated against when complaints are made c) are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery
C15	Where food is provided healthcare organisations have systems in place to ensure that a) patients are provided with a choice and that it is prepared safely and provides a balanced diet b) patients individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day
C16	Healthcare organisations make information available to patients and the public on their services, provide patients with suitable accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during their treatment, care and aftercare
C17	The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving health services
C18	Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably
C19	Healthcare organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services
	DOMAIN- CARE ENVIRONMENT AND AMENITIES
C20	Healthcare services are provided in environments which promote effective care and optimise health outcomes by being a) safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of their organisation supportive of patient privacy and confidentiality
C21	Healthcare services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises
	DOMAIN – PUBLIC HEALTH
C22	Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by a) cooperating with each other and with local authorities and other organisations b) ensuring that the local Director of Public Health's annual report informs their policies and practices making an appropriate and effective contribution to local partnership arrangements including local strategic partnerships and crime and disorder reduction partnerships
C23	Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the national service frameworks and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections
C24	Healthcare organisations protect the public by having a planned, prepared and where possible, practised response to incidents and emergency situations, which could affect the provision of normal services

Members' Council Meeting, 8 November 2007

AGENDA ITEM NO.	2.3/Jul/07
PAPER	Local Involvement Networks (LINKs)
AUTHOR	Julie Cooper, FT Secretary/Head of Corporate governance Irfan Mohammed, Engagement and Partnership Co-ordinator
LEAD	Andrew MacCallum, Director of Nursing
EXECUTIVE SUMMARY	As agreed at the July Members' Council, this paper provides an update on the situation regarding the dismantling of Patient and Public Involvement Forums and the creation of Local Involvement Networks (LINKs), for which we are an early adopter site.
DECISION/ ACTION	The Members' Council is asked to note the paper.

1.0 Progress on Local Involvement Networks (LINks)

- The Local Government and Patient Involvement Bill has been debated in the House of Lords and three key amendments have been made:

    1. NHS Trusts to have closer working partnerships with the organisation hosting the LINks.

    2. Local Authorities to have clear transitional arrangements for establishing LINKs by working jointly with PPIF members.

    3. The Department of Health will provide information and guidance on LINks governance.

- The Bill is expected to receive Royal Assent this Autumn.

- The National Centre for Involvement has evaluated the seven Early Adopter Projects and has drafted good practice guidelines which are out for consultation and in which the Hospital is taking part.

Appendix I

Local Involvement Networks (LINks)

It is envisioned that LINks will enable involvement for a greater number of people than the current system of PPI Forums. LINks will cover social care services as well as health and will be designed to reach out and include a wide range of existing local groups representing patients and the public and to provide a channel for local health and social care organisations to engage with those groups.

It will be the responsibility of local authorities to make arrangements for the establishment of LINks by contracting with a 'host' which will put in place arrangements to engage participants and form a LINk. Grants will be allocated by the DoH to Local Authorities to fund the establishment of LINks. LINks will be open to all interested parties; there will be no set membership.

Statutory functions of LINks will be:

- Promoting and supporting the involvement of local people in the commissioning, provision and scrutiny of local care services.

- Obtaining the views of people about their needs for and experiences of local care services and making these views known to people responsible for commissioning, providing, managing or scrutinising those services.

- Making reports and recommendations about how local care services could be improved to people responsible for commissioning, providing, managing or scrutinising those services.

LINks will have the following powers:

- Entering specified types of premises and viewing the services provided as well as collecting the views and experiences of users of that service.

- Requesting information and receiving a response within a specified timescale.

- Making reports and recommendations and receive a response within a specified timescale.

- Referring matters to the relevant Overview and Scrutiny Committee and receiving a response.

In view of the wider membership of LINks it was considered impractical for every member to have a right to access and inspect facilities, therefore each LINk will have a specialist team who will receive the necessary training and checks to undertake this role.

There are nine early adopter projects managed by CPPIH established to support and inform the development of LINks. Kensington and Chelsea is an early adopter.

Whilst the focus of LINks is on all aspects of social and health care, it is likely they will establish a specialist group to focus on local acute Trusts.

Members' Council Meeting, 8 November 2007

AGENDA ITEM NO.	2.4/Nov/07
PAPER	Membership Report
AUTHOR	Julie Cooper, FT Secretary/Head of Corporate Governance
LEAD	Chris Edwards, Chairman
SUMMARY	There are two statutory requirements with regards to Foundation Trust membership, the first is to increase our membership and the second is to ensure our membership reflects the diversity of our local population. This paper provides the latest membership numbers together with the targeted increase that the trust set in the annual plan for each constituency.
DECISION/ ACTION	The Members' Council is asked to note the report and offer further ideas for increasing our membership as well as ensuring its diversity.

MEMBERSHIP REPORT – LATEST STATISTICS & RECRUITMENT TARGETS 2007-08

This report provides details of Chelsea and Westminster Hospital NHS Foundation Trust's past and planned Membership by constituency.

1.0 Membership size and movements

OVERALL MEMBERSHIP OVERVIEW	Last Year	Next Year (Target)	Current Situation End Oct. 07
As at start (April 1st 2006)	10,740	13,287	
New Members	5,162	2,809	
Members leaving or changing constituency	-2,615	-1,958	
TOTAL	**13,287**	**14,138**	**13, 080**
PUBLIC MEMBERSHIP OVERVIEW	**Last Year**	**Next Year (Estimate)**	
As at start (April 1st 2006)	3,500	6,982	
New Members	4,192	837	
Members leaving or changing constituency	-710	-698	
TOTAL (at year end March 31)	**6,982**	**7,121**	**6,578**
PATIENT MEMBERSHIP	**Last Year**	**Next Year (Estimate)**	
As at start (April 1st 2006)	6,536	5,898	
New Members	969	1,769	
Members leaving or changing constituency	-1,607	-1,179	
TOTAL(at year end March 31)	**5,898**	**6,488**	**6,094**
STAFF MEMBERSHIP	**Last Year**	**Next Year (Estimate)**	
As at start (April 1st 2006)	704	407	
New Members	1	203	
Members leaving or changing constituency	-298	-81	
TOTAL(at year end March 31)	**407**	**529**	**408**

2.0 Membership Commentary

The overall membership size has decreased. The drop is mainly due to a decrease in public members. There is an increase in the patient constituency and the overall staff membership remains the same, though there is a constant flow of staff members leaving and new staff joining. A membership drive for staff is ongoing and a letter has been sent from the Chairman to all staff that are not yet members inviting them to join the trust. Going forward, we will track the number of members leaving the trust monthly, so we can measure progress.

The Membership Development and Communications Sub Committee has been discussing ways to increase public membership. We have negotiated to extend the NHS staff discount scheme to all members and this will be publicised widely and used as a further incentive for patients and members of the public to join the foundation trust.

As for the diversity of our membership, we are working closely with the Equality and Diversity Manager to audit our current membership and identify gaps in comparison to our local population. There are several methods to measure diversity. At the next meeting of the Membership Development and Communications Sub Committee will focus on the most effective means of analysis as we need to provide this data to Monitor in our annual plan.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 8th November 2007

AGENDA ITEM NO.	2.5/Nov/07
PAPER	DRAFT Minutes of the Membership Development and Communications Sub-Committee meeting held on 23 October
AUTHOR	Julie Cooper, Foundation Trust Company Secretary
LEAD	Catherine Mooney, Director of Governance and Corporate Affairs
EXECUTIVE SUMMARY	This paper outlines key issues for the attention of the Members Council.
DECISION/ ACTION	The Members' Council is asked to note the minutes.

Members' Council Membership Development & Communication Sub-Committee, 23 October 2007

DRAFT MINUTES

Present:

Council Members:

Martin Rowell (MR) - Chair
Alison Delamare (AD)
Chris Birch (CB)
Jane King (JK)

In Attendance:

Julie Cooper (JC), Foundation Trust Secretary/Head of Corporate Governance
Matt Akid (MA), Head of Communications
Jane Collier (JCo), Equality and Diversity Manager

1. Apologies and welcome:
Apologies were received from Cathy Mooney.

2. Minutes of Sub-Committee meeting held on 4 September
The minutes were agreed as an accurate record of that meeting with the following amendment:

P2, line 6 should read Chris Birches wife…

THE MINUTES WERE APPROVED

3. Matters arising from the Sub-Committee meeting held on 4 September 2007

JC confirmed that the draft presentation for the AGM had been circulated and had now been successfully presented by Martin and she thanked him once gain.

JC said that the trust intends to redesign the trust website in the longer term, and in the interim, the Foundation Trust section of the website will be corrected of any inaccuracies. She reported that the online application was now functioning properly and would confirm the application process had been completed going forward.

JC confirmed that Catherine Horne is now promoting membership to contracted staff. The staff Council Member meeting is being postponed until after the elections. The ACORN user guide had been circulated and Jane Collier was at the meeting to discuss equality and diversity of membership.

AD said that she had now promoted membership towards her peers in pathology. She also made the point that it is more difficult to promote membership when these same staff members were not included in the trust-wide thank you from the Chief Executive following the positive annual heath rating. MA said that he would check with HR to understand who is to be included in such mailings.

JC said that HR had now implemented a system for recruiting staff members to join the trust once they have been in the trust for12 months.

JC said that Derek Bell had now submitted the proposal for the development of a Research Strategy to the Trust Board and that the suggestion to create a dedicated patient and public involvement group was a part of this proposal.

4. Annual Members' Meeting- Feedback

CB said that he felt the setup was much better this year and that he felt the speeches were excellent. He said we might consider how to handle the floor and the flow of questions as some people tend to dominate the discussion. JK mentioned that the people outside the glass door seemed to have trouble getting their questions answered. CB and JK remarked on the numbers this year and MA confirmed that we were about 200 this year, which was down from the year before. MA said that he felt the reduction in numbers was in part due to the fact that the adjunct events were held on different days. CB felt that the sashes were not necessary and perhaps coloured name tags for next year.

Action: Consider holding adjunct events on the day of the AGM next year

5. Equality and Diversity/ACORN: Applications for Membership

JCo said that ACORN bases its classification on 'social class' and that it is useful but not enough. She said that the trust has its own means of profiling our patient population which includes using census data. JCo circulated a part of the workforce report which is used to analyse the diversity of our staff and allows us to compare with the local population as well as broader London as many of our staff do not come from the local community. JCo explained that we had a duty under the Race Discrimination Act, the Disability Act and the Equality and Diversity Act to monitor the accessibility of our services. She said that monitoring is key if we are going to ensure that our services meet local requirements. She gave the example of having over 300 interpreters on site to ensure our patients can communicate appropriately with medical staff. JCo said that we also had a duty to collect information around gender. She explained that we might look at how our style of communicating might impact membership. JCo proposed to do an audit at the next communications meeting in January. We can then look at overlap in data and identify gaps. JCo noted that broader trends in race and certain positions and levels within the NHS are addressed by the Royal Colleges. JCo confirmed that we do exit briefings when staff leave and that we have an external company that calls staff after 3 months to ask some questions about their time working in the trust. .

Action: Conduct a diversity audit of the membership at the next meeting

6. Membership Development and Communication Strategy: Recruitment Efforts / NHS Discounts

JC went through the action tracker which has been designed to easily track progress against the objectives in the strategy. CB said that we seem to have duplicate objectives and that this is somewhat confusing . The group reviewed the areas of potential duplication. It was agreed that this would be considered the next time the full strategy is revisited. MA asked for further information regarding the 12 month rule for staff becoming members. JC said that she would look into it.

JC noted that many of the actions had been highlighted as part of the matters arising and therefore she would only note those that had not been covered. She reported that a 30 second radio advert had now been added to the hospital radio loop and it would run 10 times per day. A two meter banner promoting membership had been produced and is available for use. The voluntary service manager is inviting all new eligible volunteers to join and the Friends and St Stephens have included the membership leaflets in their respective mailings to volunteers.

JC said in terms of promoting involvement that the trust was considering ways to involve the Membership and the Members' Council in the Healthcare Standards Declaration.

JC explained that the NHS discounts offered to NHS staff would now be extended to members of the trust and that we hoped this might serve as an incentive to join.

Action: Make a list of key actions taking place amongst key volunteer groups
Action: Make register of all proposed constitutional changes
Action: Promote the fact that NHS discounts are now available to members

7. Membership Surgeries

JC explained that the Members' Council felt Member surgeries was an area that needed looking into in terms of feasibility. JC said that she had spoken to many other Foundation Trusts and that most reported that the surgeries were unsuccessful in that members did not attend. MR said that it is important to do something to reach our constituencies to get their views or at least be available. AD suggested the stage might be an appropriate place to hold the surgeries. MA asked how we might publicise the surgeries and he noted that he felt staff surgeries would be much easier to make happen then public or patient ones.

Action: JC to draft note on surgeries and the necessary steps to trial it with a corresponding standard agenda item on the Members' Council to report back.

8. Membership Engagement

JC explained that the Members' Council had asked that a list of possible engagement opportunities be developed for further discussion. MR thought holding the open day every year was important in an environment increasingly driven by patient choice. JC explained the different ideas. MR picked up on the point of involving members in lobbying efforts and that this was an important function.

Action: JC to provide list of engagement opportunities to full Members' Council for further discussion on where to focus efforts.

9. AOB

CB said that phlebotomy wait was too long and queried what caused the delay. He asked if we could not encourage GPS to do their own blood work?

Action: Raise phlebotomy query with service manager

10. AOB

None

11. Date of Next Meeting

3rd week in January 2007

Membership Development and Communications Action Tracker

OBJECTIVE	ACTIONS	PROGRESS
Objectives - Membership recruitment		
• To develop an ongoing communications strategy to underpin membership recruitment. • To provide a simple, accessible and publicised process for becoming a member. • To take active steps to ensure the composition of membership reflects the diversity of the local communities in which we operate. • To set and meet targets for increasing membership in each constituency as set out the annual plan. • To maintain accurate and informative databases of members to meet regulatory requirements and to be a tool for developing membership. • To agree a strategy for staff recruitment	• Membership development and communications strategy updated and reviewed regularly, together with an action tracker • ISS and Haden to promote membership amongst contracted staff • Staff council members to promote membership amongst their constituencies • Circulate ACORN user guide • Implementing process to promote membership to staff upon their 12 month anniversary in the trust • Sending one off mailing to all existing staff of 12 months or more to invite them to become members • Recorded 30 second sound bite to be run 4 x per day on hospital radio to promote membership • Membership recruitment banner developed for all events	➢ Progress against objectives in strategy reviewed at every Membership Development and Communications sub-committee and shared with full MC quarterly. √ ➢ CH to promote membership amongst Haden and ISS at team briefings √ ➢ Calling meeting of staff Council Members to agree action to recruit within staff constituencies. – On Hold due to vacant posts ➢ Circulating summary ACORN user guide and discuss in detail at next meeting with Jane Collier. √ ➢ Sent 1st mailing to recruit staff entering their 12th month and this will take place on a monthly basis going forward. ➢ HR produced a list of all staff that have been in the trust over 12 months. Letter inviting each staff member to join the trust was sent to everyone not already a member. ➢ A 30 second sound bite has been produced which will run 10 times per day on the hospital radio loop to promote membership. √

Membership Development and Communications Action Tracker

	• Membership database actively managed by external company with regular diversity reporting • Meeting with volunteer manager to discuss means of promoting membership amongst volunteers	➢ 2 meter banner promoting membership has been developed and was used at AGM. ➢ Voluntary Service Manager now inviting all new eligible volunteers to join the Trust when starting. (Volunteers per se are not eligible, need to join patient or public constituency) ➢ Recruitment leaflets have been given to key volunteers to promote membership on the wards. ➢ Friends have included the recruitment leaflet in their September mailing to all volunteers.
Objectives - Managing Active Membership		
• To define active membership and ensure that interested members are encouraged and given ample opportunities to participate e.g. Open Day, Focus Groups, AGM, Consultations. • To identify methods of increasing active membership. • To monitor the composition of our active membership to gauge whether it is representative of our patients and local communities. • To encourage more members to stand for election to the Members Council. • To link with the trust's existing work and strategies on user and public involvement	• Circulated engagement database and 'PPI Guidance' • Sending Members Council notification mailing to all members for next election • Engagement and Partnership coordinator attending Communications Sub Group to share PPI work to date.	➢

Membership Development and Communications Action Tracker

particularly working with existing user groups and representatives.		
Communicating with Members		
• To develop and maintain membership communications strategy and evaluate methods of communication used. • To ensure communications are used to stimulate active membership including encouraging new candidates to run for the Members' Council. • To identify opportunities for and facilitate two-way communications between membership and Members' Council	• Sending members newsletter twice per year • Holding topical seminars throughout week of AGM	➢
Working in Partnership and Stakeholder Development		
• To identify good practice within other member organisations and share best practice • To work in partnership with other organisations to increase membership e.g. PCTs		➢ Means of involving Members' Council in Healthcare Commission Declaration being developed.

Members' Council Meeting, 8 November 2007

AGENDA ITEM NO.	2.6/Nov/07
PAPER	Membership Engagement
AUTHOR	Julie Cooper, FT Secretary/Head of Corporate Governance
LEAD	Cathy Mooney, Director of Governance and Corporate Affairs
SUMMARY	This paper provides a list of ideas and possible opportunities to involve and engage the foundation trust membership.
DECISION/ ACTION	The Council is asked to discuss the possibilities and identify which suggestions the Council would like to action and in what order of priority.

Membership Engagement: Ideas and Opportunities

- Annual Open Event: Showcase, interactive stands, behind the scenes tours
- Annual Members' Meeting: Setup members steering group
- Quarterly Members' Council Meetings: Members personally invited
- *Medicine for Members* Talk series on infection control, pain management, palliative care, stroke, diabetes, nutrition.
- Member Surgeries
- Member Research Panel
- Set up 'Access and Information' group to look at signage and patient access
- Ad Hoc Lobbying Efforts
- Conduct Membership Surveys on Key Topics

Members' Council Meeting, 8 November 2007

AGENDA ITEM NO.	2.6/Nov/07
PAPER	Membership Engagement
AUTHOR	Julie Cooper, FT Secretary/Head of Corporate Governance
LEAD	Chris Edwards, Chairman
SUMMARY	The Members' Council is charged with increasing the overall trust membership as well as ensuring that our membership play a role in providing a community perspective to solving issues and informing service change. At the last Council meeting, it was agreed that a list of possibilities and opportunities for engaging and involving members would be developed. This list is intended to stimulate further debate. Details on each of the specific suggestions will be provided during the meeting.
DECISION/ ACTION	The Members' Council is asked to discuss these possibilities and identify which of these suggestions they would like to action.

Membership Engagement: Ideas and Opportunities

- Healthcare Commission Core Standards: involve Members' Council and include views of membership in preparing final declaration

- Make Members' Council meetings more accessible to membership e.g. webcam

- *Medicine for Members* Talk series on infection control, pain management, palliative care, stroke, diabetes, nutrition.

- Member Surgeries: a set time where you can meet and discuss issues with a Council Member

- Set up 'Access and Information' group to look at signage and patient access

- Lobbying Campaigns relating to hospital services

- Conduct Membership Surveys on Key Topics e.g. healthcare preferences or new means of communication

- Annual Open Event: Showcase, interactive stands, behind the scenes tours (subject to funding from the Chelsea and Westminster Health Charity).

- Involve members on the steering groups for the Annual Members' Meeting and the Open Day

- Member Research Panel

Members' Council Meeting, 8th November 2007

AGENDA ITEM NO.	2.7/Nov/07
PAPER	Report from National Governors Forum Meeting
AUTHOR	Valerie Arends, Council Member
LEAD	Chris Edwards, Chairman
EXECUTIVE SUMMARY	This paper outlines the key issues discussed at the National Governors Forum held on 7 October 2007
DECISION/ ACTION	The Members' Council is asked to note the report and agree any specific actions going forward.

NHS FOUNDATION TRUST GOVERNORS' ASSOCIATION MEETING
at the KING'S FUND, London W.1.
Monday October 8, 2007 Report by Valerie Arends

As a representative (the term used is 'governor') of the Members Council of Chelsea & Westminster NHS Hospital Foundation Trust, I attended a meeting with other Members Council Governors from all over England at the King's Fund.

An Executive Board has been voted in, the chairman being Sharon Carr-Brown of The Royal Bournemouth & Christchurch Hospital NHS Foundation Trust. The Board consists mainly of members whose hospitals had been Foundation Trusts for as long as 3 years (whereas C&W is barely a year old).

The Executive Board has created a draft constitution which is still a work in progress – but the main thrust of the meeting was to "define the role" of the Members Council – being to
"***Inform, Influence and Advise".***

There was a lot of discussion about the relationship with the hospital's Board of Directors and many hospitals were unhappy with the lack of communication between the Board of Directors and the Members Council.

There were 2 recommendations which we might consider implementing:

1. One member of the council elected as a "conduit" to the Board of Directors and as such is permitted to attend parts of various Board meetings in an observer capacity.
2. A "buddy" system – where each member of the Board of Directors is paired with an individual member of the Members Council.

A lack of training for governors was discussed – which I think Monitor is going to address.

A tour of the hospital and its facilities should be mandatory for the Members Council.
Outside of the statutory 4 meetings per annum, many of the hospitals organised "Medical Presentations" to the Members Council on various topics of interest e.g. MRSA, NICE, Breast cancer etc.

Another 'buddy" suggestion was that the Staff Members of the Council would be paired with a non-medical Member of the Council so that information could be shared and lead to a greater understanding of the hospital.

COMMUNICATION:
Many of the Hospital Trust Members Councils produced a newsletter for their public members. It was agreed that there must be inter-action with the public members with 2-way feedback of information. (At our last meeting, we discussed an email contact for the Members Council – and I feel this should be implemented).

RECRUITMENT
Recruitment of new members was discussed. It was thought that £5 per head was the cost spent on each new member and some Hospital Trusts found they had too many public members to cope with! Many of the suggestions we have already discussed but 2 new ideas came forward:

One member of the Members Council to attend the hospital's Outpatient Clinic once a month to recruit new members of the public and local High Schools and colleges to be targeted.

Members' Council Meeting, 8th November 2007

AGENDA ITEM NO.	2.1/Nov/07
PAPER	Business Planning 2008/09
AUTHOR	Amit Khutti, Director of Strategy and Service Performance
LEAD	Lorraine Bewes, Director of Finance and Information
SUMMARY	The membership and the Members' Council play a vital role in providing a community perspective to service development. The annual service planning process sets out a clear and shared vision amongst staff, members and external stakeholders of how the Trust and individual directorates will develop over the next 12 months. This paper sets out a robust process for involving the Members' Council and builds on the strengths of last year's approach to annual planning which involved significant consultation with staff and which incorporated feedback from the Members Council.
DECISION/ ACTION	The Council is asked to review and agree the proposed approach.

Approach to Annual Planning for 2008/09

Purpose of annual planning
The annual service planning process and resulting products should fulfil several functions:

1. Set out a clear and shared vision amongst staff, Members and external stakeholders of how the Trust and individual directorates will develop over the next 12 months;
2. Set out how the Trust will deliver both excellent service quality and excellent use of resources by identifying key corporate aims and objectives, targets, planned activity and new developments and how resources will be deployed to achieve these;
3. Ensure bottom-up directorate plans are aligned with corporate aims, values, objectives and targets;
4. Capture both top-down and bottom-up plans in an overall annual plan which will serve as a basis for ongoing in-year reviews between the Executive Team and individual directorates;
5. Allows the Executive Team to provide assurance to the Board, to Monitor (the regulator of Foundation Trusts) and to the Membership Council on planning for 2008/09 and on performance against plan.

Trust approach to annual planning

We intend to build on the strengths of last year's approach to annual planning which involved significant consultation with staff and which incorporated feedback from the Members Council.

Although the details of our approach are being agreed, the broad outline will be as follows:

- The Board and senior managers will discuss the key strategic issues facing the Trust and agree key corporate aims and objectives;
- Closer engagement with Kensington & Chelsea PCT as our Lead Commissioner to ensure we have a shared understanding of the health needs and demand for acute services of our patient population;
- Directorates will develop their own plans through widespread consultation with staff. Directorate plans must take forward corporate aims and objectives, as well as developing local initiatives in alignment with the corporate aims;
- Financial and activity planning will start earlier than last year, with key assumptions and approach circulated and agreed with the directorates;
- Directorate plans will be challenged and agreed through a series of bilateral meetings with the Trust Executive team.

How would the Members Council like to get involved in annual planning for 2008/09?

We would like to understand how the Council would like to be involved in this year's annual planning cycle, and have outlined different options below.

According to the Trust constitution, one of the Members Council's roles and responsibilities is to:

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

Last year the Members Council was invited to attend workshops led by the Deputy Chief Executive and the Director of Finance and Information, to comment in particular on the Trust's draft Corporate Objectives. Valuable feedback was received from these workshops and the Objectives were refined accordingly (last year's final Corporate Objectives are attached in Appendix 1 for information).

In terms of the Members Council's input this year, we are suggesting any or all of the options below could be followed:

1. **Vision and values:** We are planning on reviewing the Trust's vision and values. The Members Council could provide valuable input into this review, for instance through a one-off workshop or by setting up a short-lived working group;
2. **Feedback on Corporate objectives:** Building on last year's approach, asking the Members Council to provide feedback on the Trust's draft Corporate Objectives once these have been discussed by the Trust's senior managers. To deepen the engagement, the Members Council, particularly but not exclusively staff representatives, could also provide valuable advice on how the Trust Executive can make these objectives 'live' within the organisation;
3. **Allocating discretionary spend:** As a Foundation Trust it is important that we create a surplus to reinvest in maintaining and upgrading our services. However, if we deliver our financial plan for this year, we will generate a reasonable surplus and are likely to be in the position of having some discretionary one-off funding available. If the Members Council thought it appropriate, they could provide direction as to what initiative(s) this one-off funding could support. Through delivering the financial plan, this funding is likely to be up to £100,000 at year-end.
4. **Involving the wider Membership:** The Council may also want to provide a means of involving the wider Membership in annual planning. One option would be for a working group to develop survey questions about development priorities for the Trust which we could mail out to the Membership.

We would appreciate the Members Council's views on whether any of the options outlined above, or indeed other options, are suitable.

Amit Khutti
Director of Strategy and Service Performance
29th October 2007

Appendix 1

CORPORATE AIMS AND VALUES 2007/08

1. Patient Experience: To improve all aspects of the patients' experience, to continue to make the patient the centre of everything we do through a focus on consistently excellent customer care and consequently be the provider of choice.

2. Clinical Governance and Safety: To maintain quality and efficiency and continuously improve patient outcomes and assure patient safety.

3. Service Line Reporting: To develop an understanding of service line profitability to support strategic service planning, investment and performance improvement and promote good business practice..

4. Teaching: To provide excellent teaching, learning and development opportunities for all staff.

5. Specialist Services: To maintain and develop our specialist services.

6. Strategic Partnerships: To develop effective partnerships with all stakeholders, including the Members Council.

7. Our Workforce: To ensure we have a highly skilled, motivated, diverse, productive and customer focused workforce.

8. Modern Infrastructure: To ensure clinical care is supported and enabled by effective modern support services.

9. Innovation: To be innovative with our clinical services and business models, using the new Foundation Trust freedoms.

10. Integrated Governance: To further develop the Trust's framework for integrated governance.

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Members' Council Meeting, 8 November 2007

AGENDA ITEM NO.	2.10/Nov/07
PAPER	Proposed Amendment to Constitution
AUTHOR	Hannah Coffey, Director of Operations
LEAD	Chris Edwards, Chairman
SUMMARY	This paper outlines a proposal to change the constitution to allow compliance with the Mental Health Act 1983 (amended).
DECISION/ ACTION	The Council is asked to approve the proposed change which will then be submitted to Monitor for approval.

PROPOSED AMENDMENT TO CONSTITUTION

1.0 Introduction

1.1 An amendment to the constitution is proposed in order to be compliant with the Mental Health Act 1983 (amended). It is the responsibility of the Members' Council to review the trust constitution and approve any proposed changes.

2.0 Background

2.1 The Mental Health Act 1983 (amended) requires a number of actions to ensure appropriate documentation and ensure the rights of individuals. It also requires the designation of a 'Manager under the Act'. The role of the 'manager' is to hear appeals against sectioning under section 23 of the Mental Health Act 1983 (amended).

2.2 The function of 'Manager under the Act' may be exercised by any three or more persons authorised by the Board of Directors, each of whom must be neither an Executive Director of the Board of Directors nor an employee of the Trust.

2.3 Before the Trust became a Foundation Trust the role of manager was undertaken by non-executive directors of Central and North West London Mental Health Trust on our behalf. Once the trust became a Foundation Trust this was no longer possible and alternative arrangements were being considered. However, a change to the legislation several months ago now allows a Foundation Trust to delegate this role, providing it is included in the terms of authorisation. Central and North West London are now also a Foundation Trust.

2.4 Work is almost complete on finalising the service level agreement (SLA) for mental health services from Central and North West London. Part of the proposed agreement would allow Central and North West London Foundation Trust to manage the Mental Health Act administration role on our behalf. The negotiation of the SLA is also an opportunity to delegate the 'manager under the Act' role.

2.5 As both Trusts are now Foundation Trusts this requires an amendment to the constitution.

3.0 Amendment to constitution

3.1 Current constitution

3.1.1 Section 12.9 Committees and delegation

3.1.2 Section 12.9.1 states 'the Board of Directors may delegate any of its powers to a committee of Directors or to an executive Director'.

3.1.3 Section 12.9.2 and section 12.9.3 refer to appointing an audit committee and a remuneration committee.

3.2 The constitution does not allow therefore delegation to anyone other than a director or a committee of directors. The proposed addition will allow delegation of a specific function to another trust.

3.3 Proposed addition

3.4 A new section to be added - section 12.9.4
Where the Trust is exercising the functions of the managers referred to in section 23 of the Mental Health Act 1983 (as amended), those functions may be exercised by any three or more persons authorised by the Board of Directors, each of whom must be neither an Executive Director of the Board of Directors nor an employee of the Trust. The Trust will delegate this function to Central and North West London NHS Foundation Trust and the arrangement will be formalised in the Service Level Agreement.

4.0 Action required

4.1 The Council is asked to approve the proposed change which will then be submitted to Monitor for approval.

Members Council Meeting, 8th November 2007

AGENDA ITEM NO.	3.1/Nov/07
PAPER	Finance Report – 6 months to September 2007
AUTHOR	Lorraine Bewes , Executive Director of Finance
LEAD	Lorraine Bewes, Executive Director of Finance
EXECUTIVE SUMMARY	It is very important for NHS organisations to deliver a strong underlying financial surplus this year in order to be fully prepared for the impact of the review of London health services stemming from 'Healthcare for London: A Framework for Action' and to cope with the reduced level of real terms growth in NHS funding following from the Comprehensive Spending Review. As a Foundation Trust, any surpluses are available to reinvest in the future development of the hospital. The Trust is reporting a healthy financial position, with nearly a £6m income and expenditure surplus at Month 6. This is £2.2m ahead of plan. The Trust does not anticipate the favourable variance to continue to the year end as there are some key risks that need to be bottomed out in the 2nd half of the year. These have been fully provided for. Therefore the forecast is to achieve the surplus plan of £5.5m. This will deliver an excellent Healthcare Commission rating for Use of Resources as achieved in 2006/07. The key risks relate to: ➢ full delivery of the savings plan ➢ the cost of delivering the priority Government target to treat patients within 18 weeks of GP referral ➢ HIV income and drugs Cash balances at the end of September remain strong and stand at £29.1m which is £4.7m ahead of the financial plan. This favourable variance is expected to move back to plan in line with the income and expenditure position.
DECISION/ ACTION	The Members Council is asked to note the financial position at Month 6.

Financial Summary to September 2007

1. Introduction

1.1. This paper summarises the financial position for the six months to the end of September 2007.

2. Overall Financial Position

2.1. The income and expenditure position to the end of September is a surplus of £5.98m, which represents a £2.2m favourable variance against plan. The in-month variance is £0.19m adverse. The YTD surplus is driven by slippage on planned developments plus over performance on tariff income.

2.2. The target surplus for the Trust was increased in Month 4 from £3.3m to £5.5m, due to the fact that the Trust has received a deficit payback from the Strategic Health Authority of £2.2m relating to the surplus achieved in 2005-2006. This is a cash neutral transaction but it will improve the Trust's Earnings before Interest, Tax, Depreciation and Amortisation (EBITDA) and Return on Assets (ROA) in year.

2.3. The EBITDA margin is ahead of plan at 11.1% for the first 6 months, compared to a planned margin of 9.6%. The risk rating at month 6 is 4, the maximum achievable until 1st October 2007 when we will have been operating as a Foundation Trust for one year. If the Trust remains on plan at the revised surplus the Monitor financial risk rating is expected to increase from 4 to the maximum 5, from Q3, although the overall rating for the Trust is still expected to remain at 4 for the whole year.

	Year to 30th September 2007				Forecast			
	Budget £'m	Actual £'m	Variance £'m	% Var	Budget £'m	Actual £'m	Variance £'m	%Var
Income	126.4	126.7	0.3	0.2%	256.0	254.3	-1.7	-0.7%
Expenditure	114.3	112.7	1.7	1.5%	233.7	232.5	1.2	0.5%
EBITDA	12.1	14.0	2.0		22.4	21.8	-0.6	
EDITDA Margin %	9.6%	11.1%			8.7%	8.6%		
Interest, Dividends and Depreciation	8.3	8.1	0.2		16.8	16.2	0.6	
Surplus/Deficit (-ve)	3.8	6.0	2.2		5.5	5.6	0.1	
Surplus Margin %	3.0%	4.7%			2.2%	2.2%		
ROA %					4.5%	5.3%		
Liquidity (days)	37.6	56.8			37.6	49.1		
Risk Rating		5			4	4		

2.4. The year to date savings plan of £3.8m is £0.43m (11%) behind plan. The Trust is forecasting to deliver £8.1m of the £8.4m savings plan by year end which is 96% of the savings plan. A further 5% has been provided against high risk savings.

2.5. The Trust forecast at Month 6 remains to achieve the revised planned surplus of £5.5m by the end of the year. A number of provisions have been retained in the forecast which explain why the current favourable variance above target is not extrapolated to the year end. These provisions include:

2.5.1. A £1.1m provision has been made against the HIV contract income relating to a risk that the base line activity assumptions in the HIV Contract are being reviewed by the HIV Commissioning Consortium.

2.5.2. A £0.49m provision against non-delivery of high risk savings targets.

2.5.3. The cost of expanding Paediatrics in the Trust, estimated to be £0.5m in 2007-08.

2.5.4. A £0.4m provision against the cost of delivering the 18 weeks activity.

2.5.5. Additional provisions have been made in Month 6 for a backdated consultant pay claim of £0.13m and £0.07m for infection control measures in relation to the Trust's MRSA action plan. These have been offset by a forecast benefit of £0.4m from provisions no longer required.

2.6. Cash at bank and in hand at 30th September is £29.1m which is £4.7m ahead of the Monitor plan of £21.2m. This favourable variance on the Monitor plan is being driven by the higher than planned EBITDA, slippage on capital expenditure and the £2.2m RAB receipt explained above.

3. Risks

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

3.1.1. Risk on delivery of the 18 weeks activity within the available funding.

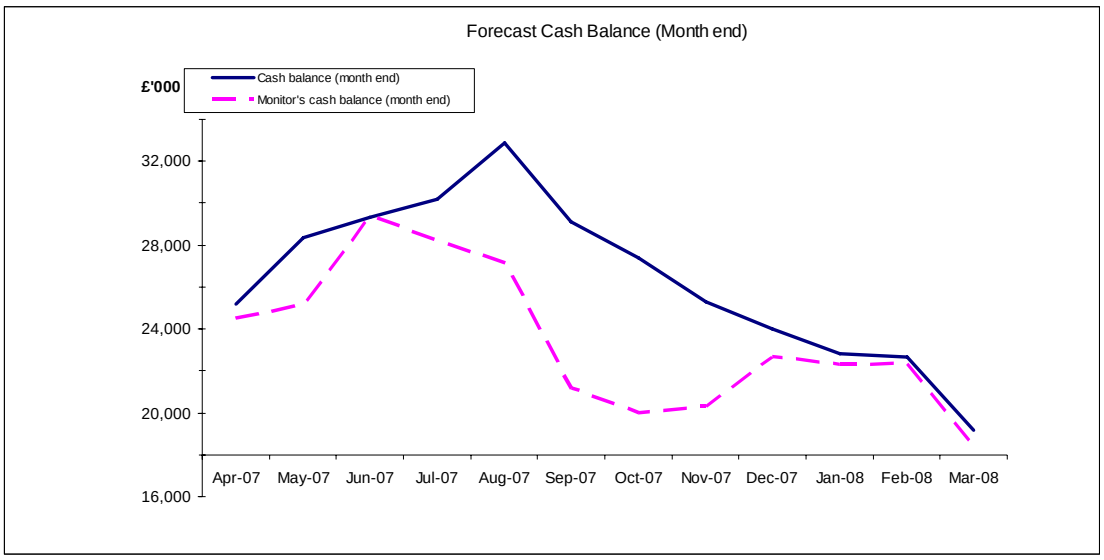
3.1.2. Risk on HIV drugs spend, due to size and variability of drug spend and a problem in reconciling the baseline activity used in the contract to the SOPHID HIV data collected. There is a potential risk of between £0.9m and £1.8m on HIV income and a provision of £1.1m has been included in the forecast.

3.1.3. Risk on delivery of the Private Patient income targets.

3.1.4. Risk on delivery of the savings programme. A provision of £0.49m has been made in the forecast against failure to deliver the savings programme.

4. Cash Position (F9)

4.1. The cash position at the end of September 2007 is ahead of plan with a balance of £29.1m compared with the Monitor plan of £21.2m. This positive variance is represented by improvements in debtor collections, I&E surplus, the RAB receipt and slippage on capital expenditure.

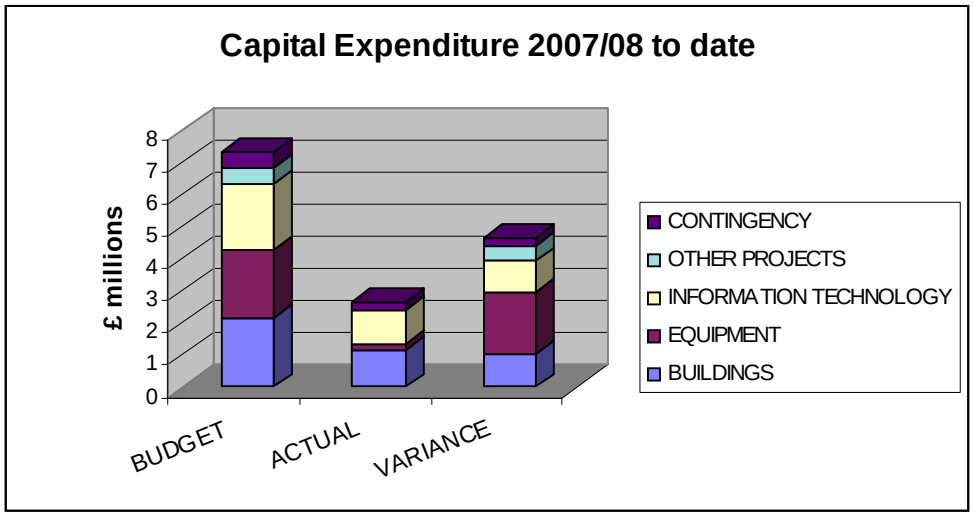


4.2. However, as illustrated in the graph above, this favourable position is expected to move back towards plan towards the year end as a number of provisions in the I&E forecast materialise, the capital programme spend recovers to planned levels and the RAB receipt is repaid**.**

5. Capital Programme

5.1. The Capital Budget for the year is £21.5m, more than double last year's programme.

5.2. The actual Capital spend in September 2007 of £0.5m is still significantly behind plan. The expenditure of £2.7m to date is 36% of the expected spend of £7.3m. There are however high value projects at the tendering stage and spend will increase significantly from December 2007.



Lorraine Bewes

Director of Finance and Information

24th October 2007

CHELSEA & WESTMINSTER HOSPITAL NHS FOUNDATION TRUST

CONSOLIDATED INCOME & EXPENDITURE SUMMARY

TRUST WIDE

FORM F1
September 07

Responsibility: Finance Director

	THIS MONTH			YEAR TO DATE			FULL YEAR			
							MONITOR	FULL YEAR	FORECAST	
	BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE	PLAN	BUDGET	ACTUAL	VARIANCE
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
INCOME										
Contract Income	(14,666)	(14,067)	(599)	(86,110)	(86,076)	(34)	(172,216)	(175,634)	(172,475)	(3,159)
Other Clinical Income (including MFF)	(3,273)	(3,084)	(189)	(19,613)	(20,202)	589	(39,118)	(39,233)	(41,062)	1,829
Private Patients	(636)	(587)	(49)	(3,811)	(3,400)	(411)	(7,516)	(7,606)	(7,014)	(592)
Other Non Clinical Income	(2,865)	(2,858)	(6)	(16,909)	(17,056)	147	(33,497)	(33,561)	(33,747)	186
TOTAL INCOME	**(21,440)**	**(20,597)**	**(843)**	**(126,442)**	**(126,734)**	**292**	**(252,347)**	**(256,034)**	**(254,299)**	**(1,735)**
EXPENDITURE										
Pay	10,819	9,624	1,195	66,747	58,615	8,131	135,281	135,989	119,758	16,231
Bank , Agency & Locum	30	1,265	(1,235)	185	7,596	(7,411)	437	355	15,763	(15,409)
Sub-total Pay	**10,849**	**10,889**	**(40)**	**66,932**	**66,212**	**720**	**135,718**	**136,343**	**135,521**	**822**
Non Pay	8,196	7,594	602	47,415	46,476	940	96,441	97,328	96,967	361
Sub-Total Non Pay	**8,196**	**7,594**	**602**	**47,415**	**46,476**	**940**	**96,441**	**97,328**	**96,967**	**361**
Deficit Reversal/Surplus Brought Forward	0	0	0	0	0	0	0	0	0	0
TOTAL COSTS	**19,045**	**18,483**	**562**	**114,347**	**112,688**	**1,660**	**232,159**	**233,671**	**232,488**	**1,183**
EBITDA	**2,395**	**2,114**	**(281)**	**12,095**	**14,046**	**1,951**	**20,188**	**22,363**	**21,811**	**(552)**
EBITDA %	11.2%	10.3%		9.6%	11.1%		8.0%	8.7%	8.6%	-31.8%
Profit/Loss on Disposal of Fixed Assets	0	0	0	0	0	0	0	0	0	0
Total Depreciation	676	657	19	3,997	3,940	57	8,224	8,224	7,672	552
Interest Receivable	(129)	(203)	74	(789)	(949)	159	(1,549)	(1,578)	(1,631)	53
Interest Payable on Loans and Leases	72	70	2	434	419	15	868	868	868	0
PDC Dividend	776	776	(1)	4,654	4,655	(1)	9,309	9,309	9,309	0
SURPLUS / (DEFICIT)	**1,000**	**814**	**(186)**	**3,799**	**5,981**	**2,182**	**3,336**	**5,540**	**5,593**	**53**

Chelsea & Westminster Hospital NHS Foundation Trust

BALANCE SHEET

Responsibility: Finance Director

FORM F6
September 07

	MAR-07 Opening Balance	AUG-07 Prior Month	SEP-07 Current Month	MAR-08 Year end Forecast
	£'000	£'000	£'000	£'000
FIXED ASSETS				
Land	50,000	50,000	50,000	50,000
Buildings	207,143	204,768	206,553	206,333
Equipment	15,928	15,020	16,216	22,145
Assets under construction	2,942	4,100	1,452	5,379
Total Fixed Assets	276,013	273,888	274,221	283,857
CURRENT ASSETS				
Stocks & work in progress	5,573	5,037	4,175	5,250
NHS Trade Debtors	4,632	6,748	6,661	4,860
Non NHS Trade Debtors	4,436	4,062	3,465	4,200
Provision for bad debts	(3,956)	(4,065)	(3,596)	(3,950)
Other debtors	1,848	1,038	1,302	1,120
Accrued income	1,198	1,937	1,917	3,490
Prepayments	671	972	921	820
Cash at bank & in hand	25,469	32,865	29,115	19,187
	39,871	48,594	43,960	34,977
CREDITORS: due within one year				
NHS trade creditors	(11,043)	(5,826)	(7,151)	(6,045)
Trade creditors - revenue	(3,475)	(1,853)	(1,431)	(2,900)
Other creditors	(3,821)	(3,766)	(4,031)	(4,940)
Tax & social security	(2,850)	(3,104)	(3,040)	(2,910)
PDC dividend creditor	0	(3,879)	0	0
Capital Creditors	(1,650)	(189)	(357)	(2,150)
Interest payable creditor	(9)	(325)	0	(8)
Current installment due on loans	(3,860)	(3,860)	(4,595)	(4,595)
Obligations under finance leases	(38)	(40)	(40)	(43)
Accruals	(6,115)	(7,158)	(6,638)	(7,770)
Deferred income	(99)	(208)	(183)	(149)
	(32,960)	(30,208)	(27,466)	(31,510)
Net Current Assets/(Liabilities)	6,911	18,386	16,494	3,467
Total Assets less Current Liabilities	282,924	292,274	290,715	287,324
CREDITORS: due after more than one year				
Obligations under finance leases	(2,235)	(2,207)	(2,214)	(2,193)
PROVISIONS FOR LIABILITIES AND CHARGES	(3,990)	(3,551)	(3,491)	(3,040)
Total Assets Employed	276,699	286,516	285,010	282,091
LOANS				
FTFF drawdown: £12.5m facility	7,059	9,666	8,931	10,295
DH working capital loan	3,125	3,125	1,562	0
	10,184	12,791	10,493	10,295
TAXPAYERS EQUITY				
Public dividend capital	162,602	164,753	164,753	162,549
Revaluation reserve	91,040	91,040	91,040	91,040
Donated asset reserve	7,843	7,735	7,713	7,584
Income & expenditure reserve brought forward	444	8,938	10,197	5,030
Surplus/(deficit) for the period	4,586	1,259	814	5,593
	266,515	273,725	274,517	271,796
Total funds employed	276,699	286,516	285,010	282,091

Members' Council, 8 November 2007

AGENDA ITEM NO.	3.2 /Nov/07
PAPER	Performance Report – Q2
AUTHOR	Nick Cabon – Head of Performance and Information
LEAD EXECUTIVE	Lorraine Bewes – Director of Finance and Information
EXECUTIVE SUMMARY	The purpose of this report is to provide information about the Trust's performance for the period ending September 2007.
DECISION/ ACTION	The Members' Council is asked to note this report.

18 Week Wait Target Delivery

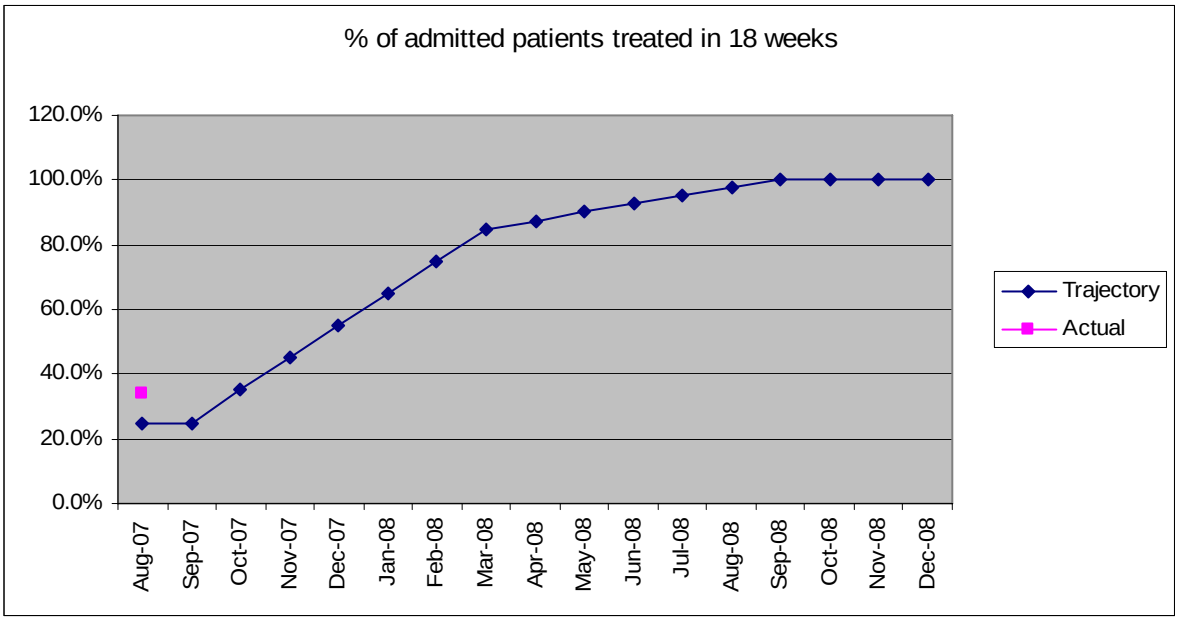
Delivery Milestones

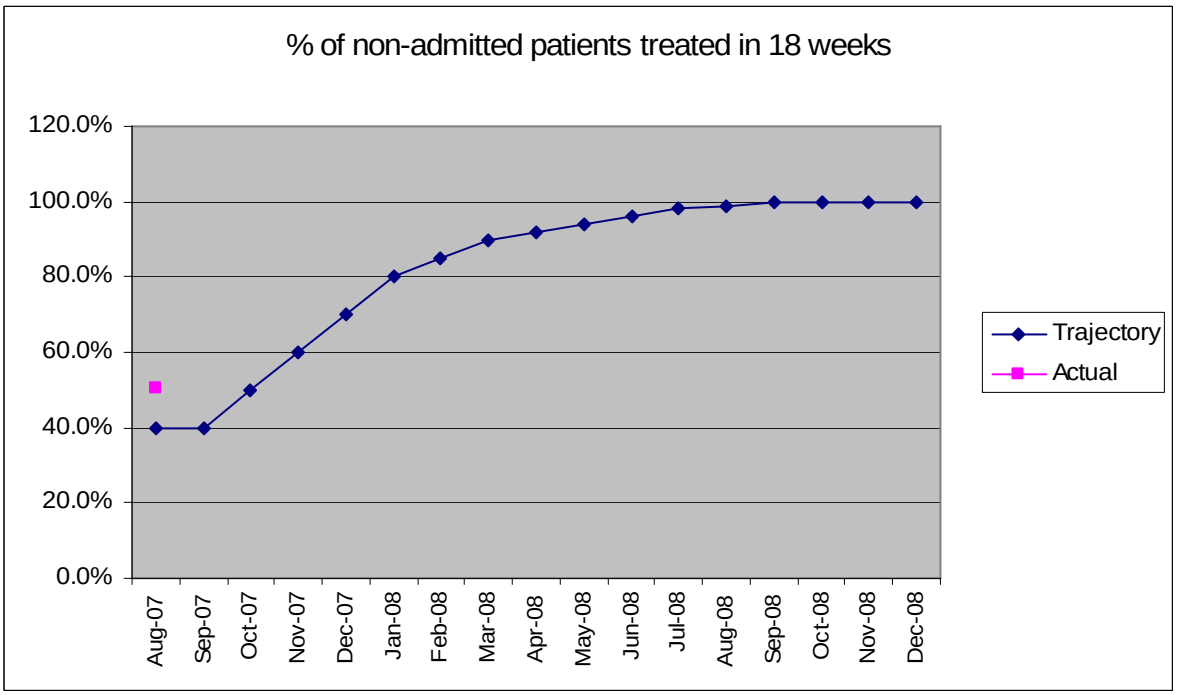
1. Overall Performance

Objective:
To monitor the overall % of patients treated within 18 weeks in line with the trajectory agreed with the PCT.

Commentary:

- We start ahead of trajectory for both the % of admitted patients treated within 18 weeks and the % of non-admitted patients treated within 18 weeks, but against a challenging trajectory;
- September information is not available due to the data warehouse IT system being down.





2 Measurement

Objective: To address the various elements preventing accurate measurement of the 18 week wait target.

2.1 LastWord Development

Deadline	Delivery Milestone	Responsibility	Update on progress
13th October	Upload phase 1 RTT upgrade to LastWord	Alex Geddes	Phase 1 successfully uploaded
24th October	Identify whether data warehouse can deliver phase 2	Alex Geddes & Hannah Coffey	Specification is being drafted with EPR (by 19th October) regarding what can be delivered in house
4th November	Agreed a timeline for implementation of Phase 2 with GE	Alex Geddes & Hannah Coffey	Progress will be decided on 24th October and is dependent on the likelihood of an in house solution

Commentary:

- The Phase 1 upgrade to Lastword now allows us to generate a 'clock start' date for all patients being referred into the trust, as well as attaching a 'unique identifier' which allows us to track a patient's progress along the pathway, as well as identify patients that are on more than one pathway
- The Phase 2 upgrade will allow us to link the diagnostic orders to the individual patient pathway, enabling us to see what is happening to patients in greater detail. This functionality will enable us to collect real demand data for diagnostic specialties and fully report on diagnostic waiting times

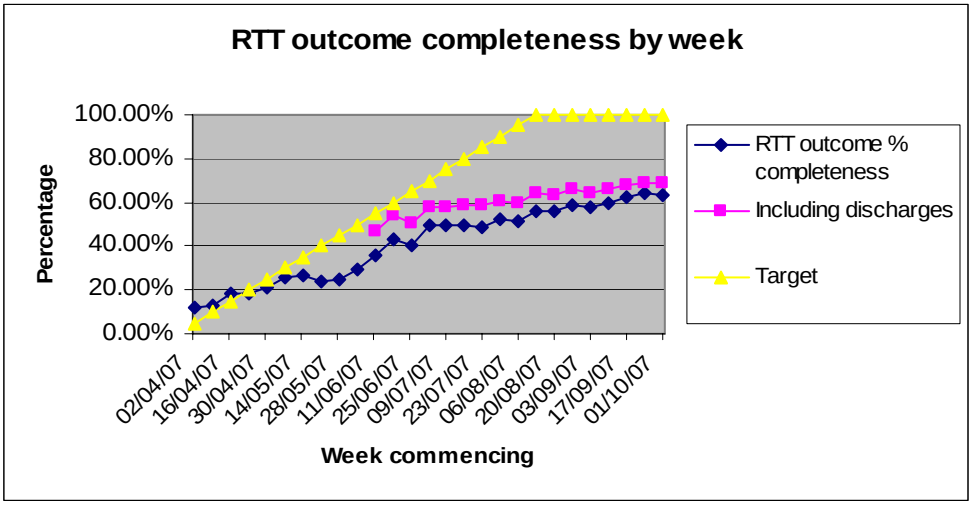
2.2 Clinic Outcome Forms

Objective:
We require consultants to complete clinic outcome forms after outpatient attendances to allow us to track where patients are in their 18-week journey.

Deadline	Delivery Milestone	Responsibility	Update on progress
End September	80% (including discharges)	Mike Anderson / Hannah Coffey / Clinical Directors / General Managers	Missed milestone.
End October	95% (including discharges)	Mike Anderson / Hannah Coffey / Clinical Directors / General Managers	Performance is improving but too slowly. Current performance at 64% RTT completeness.

Commentary:

- Recent performance has been improving but not at the requisite pace;
- Some specialties are showing close to 100% completion, which shows that this not an unreasonable target;
- We are reporting on individual consultant completion rates with Directorates taking the lead in improving performance, with support available from the Medical Director.



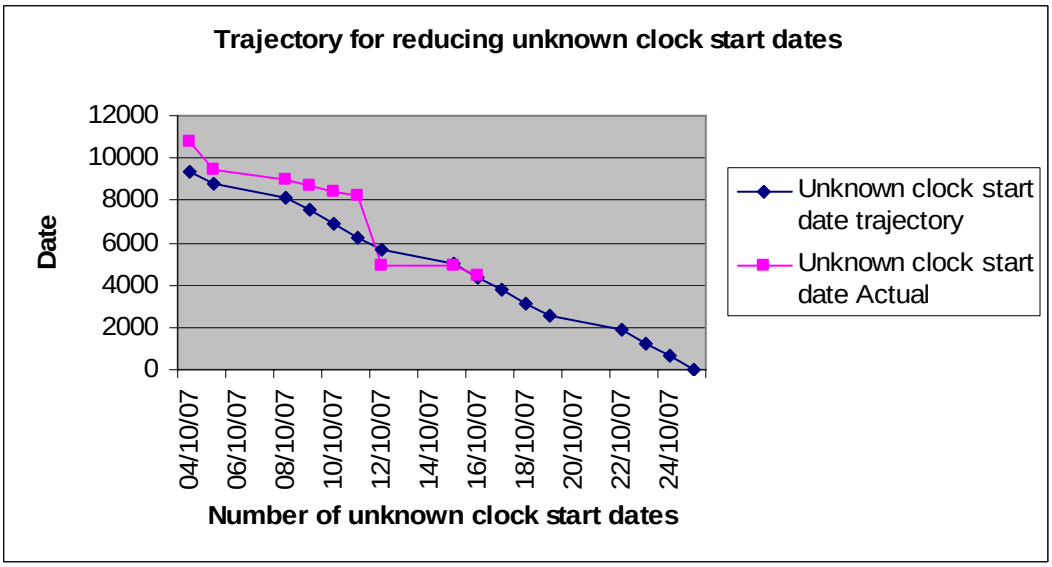
2.3 Unknown Clock Starts

Objective:
We need to know when patients were referred to us for treatment in order to be able to monitor their waiting time against the 18-week target. We must clear the backlog of patients without a 'clock-start' date and ensure all new patient referrals have an accurate clock-start date.

Deadline	Delivery Milestone	Responsibility	Update on progress
26th October	All eligible patients have clock start dates	Komal Whittaker-Axon	On track
Fortnightly thereafter	All new referrals have clock start dates	Debbie Ensor-Dean	

Commentary:

- Significant administrative resource has been deployed to clear the backlog of patients without a clock-start date;
- Almost 7,000 patients of an original 11,000 have now been cleared, with just over 4,000 remaining.



2.4 Incomplete pathways

Objective:
To identify all patients referred after 1st January 2007 who have not yet been treated, and therefore have an incomplete 18-weeks pathway.
To quantify the number of patients on the incomplete pathway that need to be treated by 28th of February (all those referred prior to 25th of October, who have already passed their 18-week breach date) and to ensure they are treated by this date, thereby eliminating the risk of breaches in the month of March caused by patients referred prior to the 25th of October 2007.

Deadline	Delivery Milestone	Responsibility	Update on progress
26th October	The status of all eligible patients is known (if pathway is incomplete it is known whether the 18 week clock is genuinely still running, and if it is, whether the patient has a booked treatment date before 1st March)	Komal Whittaker-Axon	
Weekly thereafter	Active PTL management i.e. gradual reduction of the number of 18 week eligible patients with incomplete pathways and no booked treatment date before 1st March – to zero by 1st February.	Komal Whittaker-Axon General Managers & Performance Managers	Trajectory to be developed following completion of accurate PTL on 26/10

Commentary:

- To date we have identified 18,000 incomplete pathways that have started since 1st January 2007. We are now linking these to 18 week clinic outcomes and admissions to eliminate those patients that have already been treated.
- We are currently applying rules to the data to clear out patients that do not have new or follow up appointments in the system (and have therefore already been treated), and administrative staff are currently closing incomplete pathways for those that are no longer active
- As of 26th October the only incomplete pathways should be for those patients who are still actively in our system and yet to be treated and we are developing a robust plan to ensure that all these patients are treated before 28th February 2008.

3 Waiting Time Reduction

Objective:
To ensure we are undertaking enough activity to drive down waiting times in line with our detailed operational plan and to meet our milestone waits for Outpatients, Diagnostics and Inpatients.

3.1 Additional Activity

Deadline	Delivery Milestone	Responsibility	Update on progress
Monthly	Activity on track to meet operational plan or monthly increase in activity sufficient to meet operational plan by year end.	General Managers	Operational plan being validated in light of high referral growth in some specialties

Commentary:

- Updated activity versus operational plan information to follow separately in advance of Board.

3.2 Additional Theatre Lists

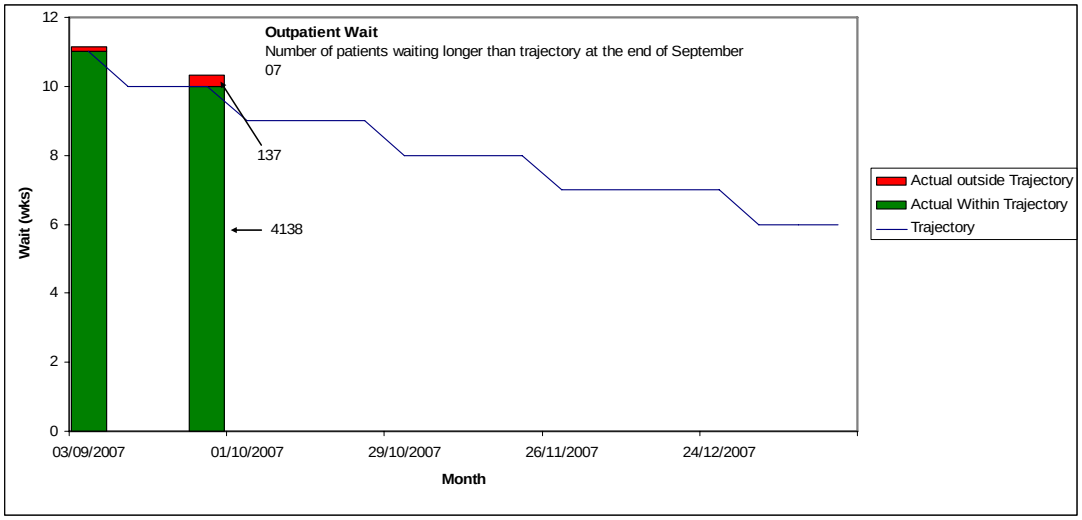
Deadline	Delivery Milestone	Responsibility	
Weekly	Extra lists are taking place in line with operational plan (see below). In total, this means that 17.7 additional lists are required per week from mid September.	Kate Hall & Sherryn Elsworth	The specialities which have not been allocated the required number of theatre lists are gynaecology, paediatric gastro-enterology and potentially plastics. External capacity options are being explored to bridge the gap. YTD demand data is also being reviewed to validate the gap. The ongoing gap and progress to resolve this will be covered in the weekly 18/52 report.

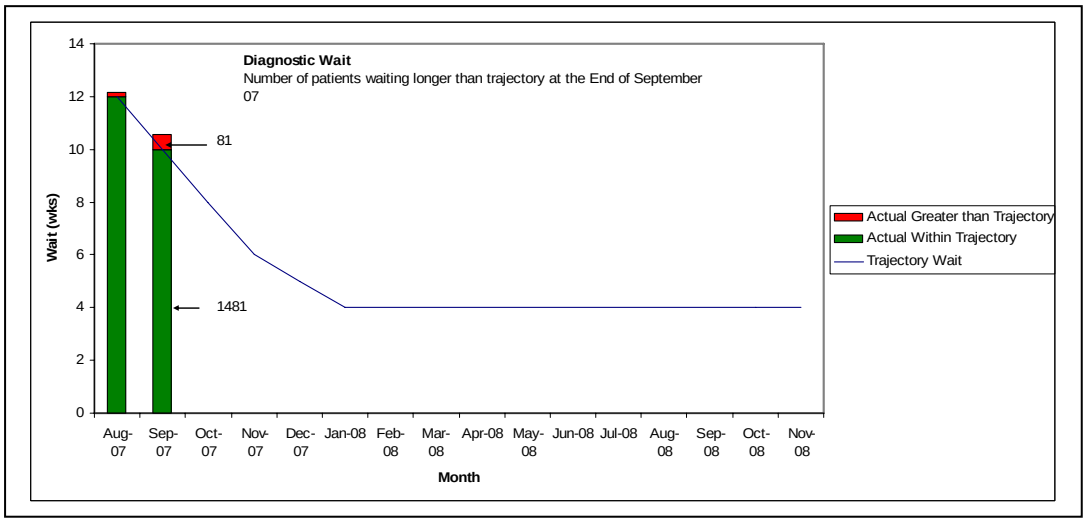
Commentary:

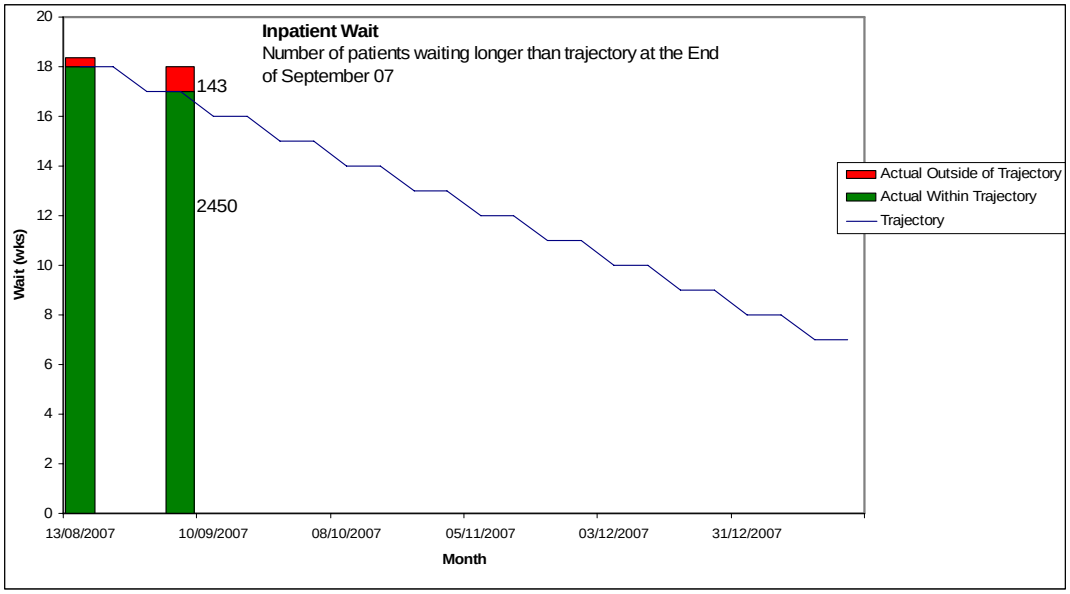
- Additional 18-week activity started in Paediatric Dental in May 2007, in the week commencing 10th of September 2007 in surgery and gynaecology and in the week commencing 24th September 2007 for other Paediatric specialties.
- **Appendix A** shows theatre activity for the Women's and Children's directorate. This will be refreshed on a weekly basis showing the activity and productivity to date for 2007/08 and weekly activity and productivity.
- Information on theatre activity for the Surgery directorate is not complete and will follow separately.

3.3 Waiting Time Reduction

Deadline	Delivery Milestone	Responsibility	Progress
Monthly	Waiting time reduction is on track against milestones (see below)	General Managers	Waiting list size reducing but still breaching internal milestones.







3.4 Income and Expenditure

Objective:
To ensure income and expenditure for 18 week delivery are consistent with plan.

Deadline	Delivery Milestone	Responsibility	Update on progress
Monthly	Income and expenditure is on track with 18 weeks plan (see below)	General Managers & Finance Team	On track

18 Week wait target Income and Expenditure

	Plan	Full year forecast	Difference
Income	£4.5m	£4.5m	£0
Expenditure	£3.0m	£3.0m	£0

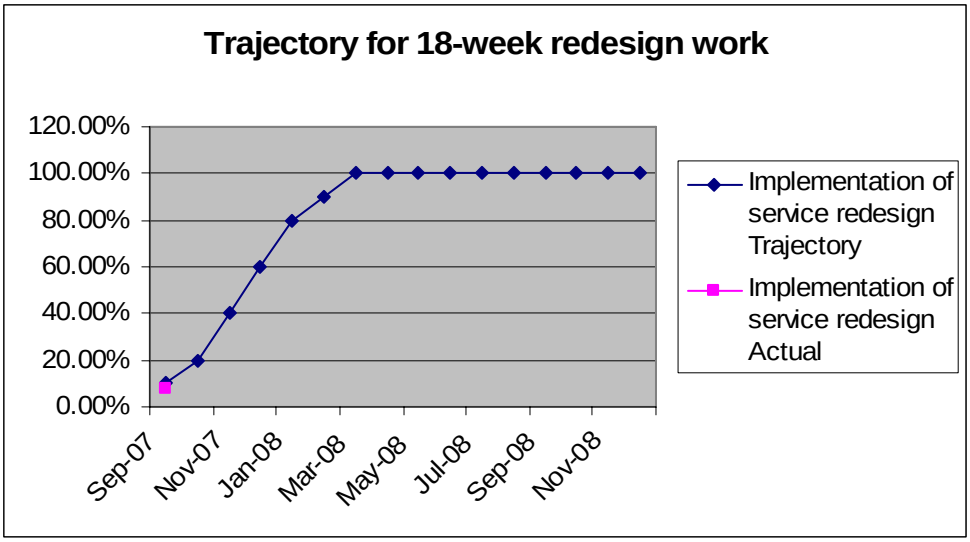
Commentary:

- Directorates originally requested £3.0m in funding to support delivery of 18 weeks; £2.8m was made available but we have reserved the full £3.0m;

- Taking income and expenditure together, the forecast at Month 6 is that we will be still on track to deliver 18 weeks within the funding envelope originally identified.

4. Redesign

Objective:
To ensure service redesign is commenced and implemented in all specialties that will benefit more from service redesign than from increased activity alone, by March 2008. To then continue to redesign all services, to ensure sustainability of the 18-weeks targets post March 2008.



Commentary:

- All specialties now have action plans on redesigning services, from changing outpatient templates to introducing one-stop shops and working with primary care in developing minimum referral criteria.
- We have successfully implemented one-stop shops in cardiology and are in the process of implementing a one-stop in urology.

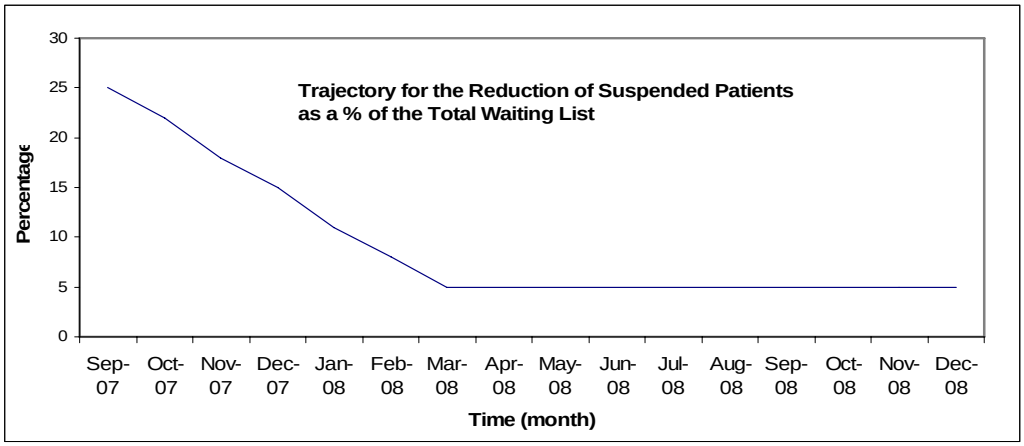
5. Other Issues

Objective:

- To reduce the number of patients who are suspended from the overall waiting list.

5.1 Suspended patients

Deadline	Delivery Milestone	Responsibility	Update on progress
Fortnightly	Progress is on track against trajectory (see below)	Kate Hall & Sherryn Elsworth	An audit is currently being undertaken by surgery to ascertain the level of suspensions and split them between medical and social suspensions



Commentary:

- September information is not available due to the data warehouse IT system being down.

5.2 Tertiary pathways

Objective:

- To ensure we have accurate 'clock-start' dates for tertiary as opposed to GP referrals.
- To ensure tertiary referrals are being treated within 18 weeks.

Deadline	Delivery Milestone	Responsibility	Update on progress
26th October	Robust information flows in place to track patient waiting times from the initial GP referral for all tertiary referrals.	Debbie Ensor-Dean	System in place, templates have been designed and the appointments office will perform this central function. Next step to work with directorates to enforce central management of tertiary referrals.
Mid November	All patients referred on from C&W have data that meets the minimum data set sent on with the referral.	Debbie Ensor-Dean	On track.
TBC	Tertiary referral patterns mapped (so that % from internal consultants & other trusts is clear and within that, the specialty split is known)	Komal Whittaker-Axon	High volume referrers have been identified to key specialties (E.g. plastics, urology)
TBC	Streamlined pathways in place for the most common tertiary pathways.	Komal Whittaker-Axon	Urology work commenced, Plastics and orthopaedics to be commenced

6. Information

Objective:

A comprehensive and accurate suite of performance information needs to be available on a weekly/fortnightly/monthly basis to enable delivery of the milestones outlined above.

Commentary:

- A list of priority information has been developed and agreed with the Information Team. The suite of reports includes analysis of average waiting times for the main points of delivery; a breakdown of the RTT responses; performance against waiting time trajectories; referral and activity trend analysis. Draft reports are now being refined.

Deadline	Delivery Milestone	Responsibility	Update on progress
End October	All information produced as per agreed schedule in useable format.	Nick Cabon	Information reports are being refined.

Appendix A: Theatre activity and productivity 2007/08

Table 1. Women's and Children's inpatient activity and productivity to month 6, 01/04/07 – 30/09/07

	Normal activity			18-weeks			Total				Productivity				
Specialty	2007/2008 Plan to Month 6	Acutal number of patients seen	Variance between planned and actual	2007/2008 Extra 18 Weeks Plan to Month 6	Acutal number of patients seen	Variance between planned and actual	Additional number of patients planned	Acutal number of patients seen	Variance between planned and actual	Actual Number of lists to Month 6	Average Cases Per List 2006/2007	Planned Average Cases Per List 2007/2008	Actual Average Cases Per List 2007/2008	Comments	Actions to bring us back on track
Paediatric Craniofacial	101	100	-1	0	0	0	101	100	-1	17	3.29	4.53	5.88	5.88 artificially high as includes Main Theatres cases but not Maint Theatre Lists	
Paediatric Dentistry	567	520	-47	171	198	27	738	718	-20	169	3.99	4.34	4.25	4.25 might be artificially high as includes sedation patients not treated in Paeds Theatres	
Paediatric ENT	135	179	44	6	15	9	141	194	53	54	3.15	3.32	3.59		
Paediatric Gastroenterology	157	267	110	11	8	-3	168	275	107	39	3.68	5.02	7.05	7.05 very high as includes both Theatre and Non-Theatre Activity	
Paediatric Surgery	502	474	-28	8	20	12	510	494	-16	152	2.60	3.00	3.25		
Gynaecology DC	639	637	-2	16	11	-5	655	648	-7	145	3.59	3.96	4.47	Have included 130 ERPCs (non-electives) in actual activity	
Gynaecology IP	425	439	15	20	7	-13	444	446	2	131	2.71	3.08	3.40		
W&C Total	**2525**	**2616**	**92**	**231**	**259**	**28**	**2756**	**2875**	**119**	**707**					

END OF THE 18 WEEK WAIT TARGET REPORT

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council, 8 November 2007

AGENDA ITEM NO.	3.2 /Nov/07
PAPER	Performance Report – Q2
AUTHOR	Nick Cabon – Head of Performance and Information
LEAD EXECUTIVE	Lorraine Bewes – Director of Finance and Information
EXECUTIVE SUMMARY	The purpose of this report is to provide information about the Trust's performance for the period ending September 2007.
DECISION/ ACTION	The Members' Council is asked to note this report.

Chelsea and Westminster Healthcare NHS

NHS Trust

PERFORMANCE REPORT FOR THE PERIOD JUNE 2007

1. PURPOSE

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

2. CONTENT OF PERFORMANCE REPORT

2.1. The report comprises of the following components:

- **External Dashboard – pg 5**
- **Internal Dashboard – pg 6**
- **Appendices**
  - **Activity Summary – pg 7**
  - **Efficiency and Resources Summary – pg 8**
  - **Access Summary – pg 8**
  - **HR Summary – pg 9**
  - **SLA Performance Summary – pg 10-13**

3. SUMMARY OF PERFORMANCE REPORT

3.1. The Trust is on schedule to fully meet all of the Monitor targets with the exception of the MRSA target. We are on track to achieve seven of the other Healthcare Commission indicators; however we are currently underperforming on the Clostridium Difficile Rate target and data quality on ethnic group. If the Trust failed to attain the MRSA target the Trust could still achieve a rating of excellent provided all the other targets are fully met.

3.2. There has been 1 breach of the Outpatient Waiting Time target this year. It occurred in orthopaedics and was the result of a breakdown in process. The Surgical Directorate and the outpatients managers have reviewed the process to ensure there are no further breaches of this kind. Additionally an incident review is scheduled to occur within the next month between the Head of Outpatient and Booking and the Directorates to ensure future occurrences are minimised.

3.3. The Trust Board should note that the Department of Health's recorded MRSA target for the Trust in 2007/08 is to have no more than 12 cases of MRSA bacteraemia. We believe our target should be to have no more than 15 cases in 2007/08, and are pursuing this with Monitor too see if they will accept an amended target. If this does not work we intend to escalate this with the Department of Health. The Trust is also implementing a plan to reduce the risk of future cases of MRSA including reviewing the policy for insertion of central venous lines.

3.4. The Trust is also on track to achieve all of its internal quality targets (ref. p6) with the exception of Deaths following Selected Interventional Procedures and Emergency Re-admissions following Discharge. The constructs for both these targets are being reviewed to ensure they are tracking meaningful data for the Trust.

3.5. New outpatient attendances year-to-date is 2.7% lower than the plan for the period. The follow up attendances are 11.5% higher than planned, but are 12.5%

lower than in the first quarter of last year. Our new to follow up ratio is 2.57 versus a target of 1.94.

3.6. Elective Day case activity was below plan YTD by 11.3%. However the trust has demonstrated a recovery from its previous position at month one of 20% below the plan. Elective activity is 0.8% lower than planned. Additionally the elective activity (inpatient & day case) is 3.2% greater than the activity for the corresponding period last year.

3.7. The Trust Board should note that the Trust has scored poorly against the convenience & choice target specifically on availability of slots within 13 weeks as shown on the Choose and Book system. The Trust believes that it was exempt from being assessed against this indicator and is endeavouring to make a claim of extenuating circumstances to the Healthcare Commission.

3.8. The trust intends to begin monthly monitoring of key indicators linked to the quality of our stroke service. This is to enable us to monitor those aspects of the service that commissioners in NW London have highlighted are most importance to them.

4. EXTERNAL TARGETS

4.1. The Trust is on schedule to fully meet all of the Monitor targets with the exception of the MRSA target. There have been 5 cases so far this year compared with a target trajectory of 3 cases.

4.2. The Trust's rate per 1000 bed days of Clostridium Difficile is 1.92. This is 0.42 higher than the target rate for the year.

4.3. The Trust has recorded a valid ethnic category code for 94.1% of admitted patients. This is only just short of the 95% target. Three directorates are performing above the target. The exception is Surgery A&I who have a rate of 92.3%.

5. INTERNAL INDICATORS

5.1. The Trust is on track to achieve all of the internal indicators with the exception of Deaths following Selected Interventional Procedures and Emergency Re-admissions following Discharge.

5.1.1. There have been 5 deaths following selected interventional procedures so far this year, and the performance rate to date is 2.1% compared with a target of 1.5%. Details of each death have been sent to the relevant directorate for investigation. The construction of this indicator is being refined to ensure that it is appropriate.

5.1.2. The Emergency Re-Admission Rate (11.8 %) is 0.4% higher than the target. Details of the re-admissions have been sent to the relevant directorates for investigation. The construction of this target is being refined because it does not distinguish between readmissions for the same condition which are a concern and readmission for a separate condition which may be wholly unrelated to the initial spell.

6. ACTIVITY SUMMARY

6.1. New outpatient attendances year-to-date is 2.7% lower than the plan for the period, but is 29% higher than the corresponding period lat year. The follow up attendances are 11.5% higher than planned.

6.2. The Trust plans to treat a much higher number of elective patients this year in order to achieve the 18 week target. Day case activity in the first quarter was 11.3% lower than the SLA plan. However, the actual level of activity was nearly 2% higher than in 2006/7.

6.3. Elective inpatient activity is 3.3% ahead of the SLA plan through the first 3 months, and is over 7% higher than in the first quarter of last year. The directorates are devising their operational plans for the year, and these should be finalised in the next month.

6.4. The non-elective inpatient activity is 3.7% lower than plan and over 10% higher than the corresponding period last year.

6.5. Overall the A&E attendances were 0.41% higher than plan even though the paediatric attendances were 16.3% lower than plan.

7. SLA PERFORMANCE SUMMARY YEAR END

7.1. Overall outpatient activity significantly over-performed with the exception of A & E attendances, which was below plan by 1.6%.

7.2. The SLA financial position at the end of quarter one was a surplus of £490k

7.3. The single largest category in deficit versus plan was the ''critical care' category. This is broken down on page 13 for your information.

7.4. The largest single contributor to the Trust having a surplus at the end of quarter one was non elective in excess of planned with a surplus of £1437k. Other contributors to surplus in order of magnitude were non elective excess bed days (£128k), elective excess bed days (£105k) and A&E (£47k).

8. HR INDICATORS

8.1. The Trust has shown a decrease in staff in post for June, largely due to Doctors and qualified nurses leaving. Of the 5.00 wte doctors who left, 4.00 wte of these were on rotation from Surgery. There were 8.00 wte qualified nurses who left, they mainly specified 'relocation' as the leaving reason - half of the all the nurse leavers were from Theatres. As a result of this, the vacancies have marginally increased (by 0.4%) until we replace them.

8.2. 'Hot spot' staff groups for vacancies in June were Nursing & Midwifery qualified staff (167.42 wte nurses), Allied Health Professionals (mainly Physiotherapists) and Admin & Clerical staff. The most A&C vacancies can be found within the Mgt Executive directorate (44.91 wte in total, accounting for nearly half of all A&C vacancies). These are specifically in Corporate Nursing, Governance, IT and Finance. The Trust as a total has 96.63wte A&C posts vacant.

8.3. There has been the greatest turnover within Clinical Support (Therapies) and A&I this month, with 1.67% and 1.43% of staff leaving, respectively. The reason for leaving generally being 'relocation', or 'other'.

8.4. Overall Bank and Agency activity is down on this time last year, however there has been an increase in Bank usage this month, particularly in Mgt Executive. This has been in the A&C staff group, spread across all areas of the Directorate. Other Directorates that have shown an increase of more than 5% since last month are Surgery, and Women & Children's. Again, this is with A&C staff. Women &

Children's have shown nearly 7.00 wte reduction in agency nursing staff, and Medicine directorate a 5.00wte reduction.

8.5. A&I have again shown an increase in Agency nursing activity this month, now at 21.79 wte – 4.5 times higher than this time last year. The majority of this being attributed to Theatres.

8.6. Within Women & Children's, 45% of all B&A nursing and midwifery usage come from Maternity team (not including private maternity). There have been small increases in some other Directorates, but overall Agency nursing staff usage is down by 10.00 wte on last month.

9. EFFICIENCY AND RESOURCES

9.1. The Trust's new to follow-up rate for outpatients is currently 1:2.57. 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 – in 2006/7 we were not be allowed to offset good performance in one specialty against missing the target in a different specialty.

9.2. The targets for day case rates, length of stay, occupancy rates and day of surgery admission rates have not been set yet. The directorates have been asked to set these and they will be reflected in future Performance. (Action: Deputy Chief Executive). The overall day case rate for the Trust is 72.5% - a 0.5% improvement on the same period last year. Performance against the selected basket of day case procedures is nearly 69% compared with a target rate of 73.4%.

9.3. The Trust has been improving the timeliness of clinical coding. There is a target to complete all diagnostic coding within 7 working days of the patient's discharge. It is currently taking 8 working days to complete the coding at the end of the month. The Trust had planned to achieve the 7 day target during the month of July.

10. CONCLUSION

10.1. The Trust performed well in many of the external indicators. However we need to ensure that it keeps abreast of the C difficile and MRSA targets, because they are tighter than last year and more difficult to recover from if performance does not improve soon.

10.2. There has been a breach of the Outpatient Waiting Time target. It is essential that the Trust does not have any further breaches of this or any other access targets – particularly those that contribute to the 18 week target.

Nick Cabon
Head of Performance and Information
18th July 2007

Disability Equality Scheme
2006 – 2009

Action Plan